An Evaluation of Specific Nursing Interventions in the Management of Patients Suffering from Manic Depressive Psychosis.

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This work is dedicated to the memory of my father

Joseph C. Barker (1919 - 85)

Illnesses are almost always spiritual crises in life in which old experiences, and phases of thought, are cast off in order to permit positive changes.

Josef Beuys (1921 - 1986)

CONTENTS

LIST OF TABLES AND FIGURES

LIST OF APPENDICES

ABSTRACT

An Evaluation of Specific Nursing Interventions in the Management of Patients Suffering from Manic Depressive Psychosis.

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This study examined the effect of three different nursing interventions in the management of women diagnosed as suffering from manic depressive psychosis. The thesis was presented in three parts.

In Part One, an examination was made of the role of the nurse in caring for patients suffering from affective disorder in general. Four sub-studies were used to define the construct 'routine nursing care'. These comprised: a critical appraisal of (1) the training and (2) the examination of Scottish nursing students; Scottish nurses' perceptions of their role in caring for, (3) patients with manic depressive psychosis and (4) patients with affective disorder in general. These sub-studies suggested that psychiatric nurses were trained to offer a general, supportive, pattern of care to all patients suffering from affective disorder. No clear difference was found between the role perceptions of nurses caring for 'depressed' patients in general, and those caring for manic depressive patients in particular.

In Part Two, a further sub-study (5) examined a specific psychological construct, locus of control, within the context of women diagnosed as manic depressive psychosis, in remission. This study suggested that women with a history of depression-only, differed from a normative sample on one scale, with both depression-only and mania and depression subjects differing from each other, and from the normative sample on a second locus of control scale. In a final sub-study (6) a new locus of control scale scale was developed to measure the the patient's expectations of her capacity to influence her status as a sufferer from affective disorder. Sub-studies 5 and 6 suggested the possible role played by the locus of control construct, as a mediating factor in the precipitation and maintenance of major affective disorder.

In Part Three, the main (experimental) study compared the effect of three discrete nursing interventions, Routine Nursing Care, Self Evaluation and Modified Cognitive Therapy, on measures of four dependent variables characteristic of depression, and satisfaction with care and treatment. The results suggested that, despite the absence of significant between-group differences on all measures of the dependent variables, the Modified Cognitive Therapy intervention showed more clinically significant changes on three of the clinical variables, and that subjects in the MCT group become more internalised on the locus of control measure. This, suggests that the MCT group subjects' view of their capacity to control external sources of reinforcement, might have increased as a function of exposure to the training in self-management inherent in the MCT intervention. The implications of these findings for psychiatric nursing education and practice are discussed.

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CHAPTER 1

INTRODUCTION

From Insanity To Illness

The science of psychiatry is a young one indeed. At the turn of the century, Freud and his colleagues tried to build a scientific model of psychological man which revolutionised the attitudes of many to mental disorder, its genesis and treatment. Although influential, the psychological school had its opponents and detractors. Those who were in charge of more seriously disordered patients, and who disapproved or despaired of the analyst's metaphysical attempts to solve the intrapsychic problems of the insane, continued to experiment with what appeared, by present standards, to be desperate, ill-considered and 'unscientific' courses of action. Psychosurgery, the most radical 'cure' of all was greeted as a promising innovation in the early 1940's, but has since been seen by others as merely another chapter in the history of drastic biomedical intervention (Valenstein, 1986). Critchely comments thus upon the inevitable inclusion of brain surgery in the armamentarium of modern psychiatric techniques:

> The failure of conservative measures to alleviate symptoms and behaviour of a large and captive population of psychotics encouraged the introduction of procedures which were reckless, drastic, traumatic and crude...dangerous methods inducing states of hypoglycaemia, smothering, suffocation, hypothermia, electroshock, or convulsant drug-intoxication were deliberately employed (Critchley, 1986, p.7).

All these 'drastic' interventions arrived before this century was thirty years old, leading Partridge to write of the psychoses that their:

> ...stubborness and resistiveness to treatment, expose so clearly the ignorance of their pathology and aetiology that they arouse aggressive reactions in the baffled and frustrated therapist (cited by Critchley, 1986, p.7).

Over the past thirty years, views about mental disorder have changed markedly once again, with a burgeoning theoretical literature on the aetiology of psychiatric illness. Even the radical hypothesis that the traditional conceptual basis of mental *illness* is largely mythical, has become almost commonplace (Moore, 1975). Szasz's (1962) original assertion that *mental* illness, *per se*, does not exist, but represents physical illness with mental symptoms, may not have received widespread official support, but his argument has led others to challenge the factual basis of the state we call mental disorder. Kendell (1983a) appears to take Szasz's argument a stage further when he asserts that:

> ...(all) diseases are merely concepts, man-made abstractions justified only by their convenience and liable at any time to be adjusted or discarded (Kendell, 1983a, p.208).

He emphasises that mental disorders are *invented* rather than *discovered*. We continue to use traditional terms like schizophrenia or manic depressive psychosis only because "the concepts they represent make it easier to comprehend the variegated phenomena of insanity (sic)[p.208]". It is clear, however, that researchers and clinicians have begun to acknowledge more and more the possible distinction between disorders which may have a physical base and those which Szasz would call 'problems of living'. The continued search for an identifiable biophysical basis for some mental disorders, expressed mainly through the growth of neuroscience, has accentuated the distinction between disorders which are thought to be of psychosocial

origin, such as some anxiety states, and those where some organic or physiological origin is assumed, as in the case of schizophrenia. The treatment of these two 'classes' of mental disorder also has displayed marked differences. Psychosocial problems, traditionally classed as the *neuroses*, usually are offered some form of psychotherapy, with optional medical treatment, whereas disorders with an *assumed* biophysical base, the *psychoses*, usually receive medical treatment with optional psychotherapeutic support. The importance of such a distinction, for the future development of psychotherapy, has been emphasised by some psychologists, such as Eysenck (1976).

Affective disorder

Depression is one of the oldest recognisable psychiatric disorders, with descriptions of depressive states existing as early as the second century A.D. in the writings of the physician Aretaeus (Kendell, 1983b). The semeiology of the disorders of affect has, however, always been the poor relation of descriptive psychopathology (Berrios, 1985), with several examples of the difficulty encountered in developing a descriptive language for affectivity, as distinct from disorders of thinking, occurring throughout the history of psychiatry (Bleuler, 1906; Chaslin, 1912; Ribot, 1897). The view that all disorders of affect exist as a function of thought disturbance has been held at least since the nineteenth century. The view that feelings play only a secondary role in the definition of human nature dates back almost to ancient Greece (Berrios, 1985). Indeed, the term 'feelings' represents the widest and most abstract of a family of statements about subjective experience which includes mood, sentiment, passion, emotion and

propensity. Such feelings are defined generally in a negative fashion, as experiences which are neither cognitive nor volitional (Berrios, 1985). Contemporary aetiological models continue to define affect in terms of disturbance of thought or behaviour.

The term 'affective disorder' is used universally as the modern label for a class of disorders in which disturbance of mood is prominent, and considered fundamental. Where the disturbance is characteristically severe, it is often described as an affective *psychosis* (Kendell, 1983), which is the contemporary equivalent of Kraepelin's (1921) term 'manic depressive psychosis'. The prominent feature of any affective disorder is a phasic change in vitality. This is shown psychologically in disturbances in the cognitive and affective spheres, somatically in loss of drives for food and sex and in both areas in changes in rhythmns. Where mania is evident these features are reversed, with acceleration of cognitive functioning and motor behaviour and a marked elevation of mood. Although it could be argued that there are many specific affective disorders within this grouping, mania and depression, occurring separately or alternating, are most common.

Clinical depression can be distinguished from 'natural depression' where psychological pain arises from some unpleasant life event. Such 'melancholy' eases with the passage of time, often leaving a legacy of understanding if not psychological growth. Pathological depression may involve a similar experience of sadness, but one which seems to be an exaggerated response to the precipitating event. This not only disrupts the person's life but may pass only to recur fitfully, or on some kind

of schedule, each re-occurrence recreating the pain of the initial experience.

Historical roots of the definition of depression. Zilboorg (1944) suggested that the symptoms of depression had remained unchanged across twenty-five centuries. Differing views of clinical depression across the history of psychiatry may have more to do with theoretical concepts than with the actual presentation of the patient. This is evident in the historical reviews of the concept provided by Lewis (1934) and Zilboorg (1941). Falret first distinguished between melancholia and episodic depression, with his introduction of the term 'folie circulaire', observing also that the disorder appeared to run in families and most affected women. Kraepelin extended the 'scientific' view of mental disorder greatly with his nosological system which distinguished between *dementia praecox*, later termed schizophrenia, and *manic depressive insanity*, which embraced 'folie circulaire', all melancholic and manic states, single or recurrent, and various other morbid fluctuations of mood (see Braceland, 1957). His most significant contribution may, however, have been his reinforcement of the medical model of psychiatry, taking the view that all psychiatric disorders had an (as yet) unidentified organic basis and would follow a predictable course. The distinction between manic depressive insanity and dementia praecox in terms of the resultant effect on the functioning of the person, was a prime example of the model in practice. In Kraepelin's view, manic depressive psychosis seemed unrelated to the patient's environment and life style. He assumed, therefore, that the aetiology

of manic depressive psychosis was rooted in heredity, constitution or metabolism.

Endogenous and exogenous depression. Meyer (1908) was a notable dissenter to Kraepelin's concept of psychiatric illness as a mental equivalent of physical disease. He rejected the notion of depressive disorder arising purely from a physical cause, suggesting instead that depression arose from the interaction of some precipitating factor, or life event, with the constitutional make-up of the individual. This conflict of opinion on the root of depressive disorder remains unresolved to the present day. Traditionally, some depressions have been described as 'reactive', or *exogenous*, stemming from an apparent aversive life event. The use of the concept 'endogenous' in relation to depression may originate from Bonhoeffer's (1910) term 'exogenous reactions' in which he was referring to diseases of the brain caused by external toxic agents (cited by Arieti, 1980). Where such an environmental trigger is not obvious the depression is termed 'endogenous', arising from within. Arieti (1980) has suggested that American psychiatry gave an undue emphasis to the concept of reaction in depresssion, missing Meyer's acknowledgement that a defect *within* the individual was stimulated by some environmental factors. Ariskal (1979) recommended that the term endogenous should be discarded "as it implies etiologic independence from environmental influences (p.415)".

The classification of affective disorder: binary and unitary theory. Kendell (1976) suggested that although a number of depression classifications exist there is little to choose between them. Spitzer's

Research Diagnostic Criteria (Spitzer *et al.*, 1978) provided operational criteria which facilitate independent classification of nine distinct depressive states, the most important categories being uni-polar and bi-polar major depressive disorder, and endogenous major depressive disorder. Under this classification, Kraepelin's 'manic depressive insanity' is split into two categories of *recurrent* mood disturbance: either uni-polar or bi-polar disorder. When recurrent depression *or* mania only is evident, the illness is classified as uni-polar. Where depression and mania alternate, the term bi-polar is used. Although this distinction is commonly accepted, Perris (1966) suggested that almost one half of patients diagnosed as uni-polar will become bi-polar in subsequent episodes, suggesting that it is an as yet incomplete classification system (Shaw, Kellam and Mottram, 1982). Awareness of such an eventuality has encouraged most psychiatrists, in Britain at least, to classify all forms of recurrent and severe depression as manic depressive psychosis (Naylor, 1987).

The unipolar/bipolar distinction is only one of the dichotomous classification systems in current use. Others include the distinction between *primary* and *secondary*, *endogenous* and *reactive*, and *psychotic* and *neurotic* depression. Although each system has some prognostic value, they represent, primarily, mechanisms for the classification of symptoms and their hypothetical aetiology. These dichotomous classifications stem from Kraepelin's original formulation, which stipulated two depressive types - manic depressive psychosis and psychogenic depression. Such a distinction between 'psychotic' and 'neurotic' types of depression evolved in American psychiatry (Levitt,

Lubin and Brooks, 1983). In Britain, Lewis (1934) argued that the Kraepelinian binary conception of depression was based simply on two extremes of a single continuum of *severity* of illness. Manic depressive psychosis and 'reactive', or psychogenic depression, in his view, were not seperate illness types.

Several factor analytic studies, using multivariate statistics, have challenged Lewis' view. Mendels and Cochrane (1968) reviewed seven factor analytic studies, each of which derived a general and a bipolar factor. They observed a fair degree of agreement among the studies on the symptoms comprising the bi-polar factor: these were relatively consonant with the conventional clinical view of the endogenous type of depression. Despite this apparent concordance, the studies, in toto, are seen as unconvincing, especially in the light of serious methodological defects (Levitt, Lubin and Brooks, 1983). Kendell (1969) was one of the first to argue that factor analysis demonstrated nothing more than the impact of the clinicians' theoretical biases upon a research attempt to classify depression. In a critique of specific factor analytic studies, Kendell pointed out that the studies used clinical ratings from psychiatrists who believed in the binary theory of depression. In his view the experimental analysis "naturally" confirmed these theoretical leanings. In Levitt, Lubin and Brooks' (1983) view, factor analysis was a useful statistical tool, but was no more than that: "like a computer, it does not distill truth from buttons and beans (p.27)". In their view factor analysis, or any mathematical technique, is bound to reflect the biases contained in

information which is weighted according to an underlying theory, such as the unitary/binary concept.

The binary distinction, between biological and non-biological (or psychosocial) depression, continues to receive critical attention. Recent studies have provided further support for Lewis' view that the distinction between 'situational' or *reactive* depression, and 'non-situational' or endogenous depression, is invalid (Ariskal, 1979; Garvey *et al.*, 1984). These authors suggest instead that *major depressive disorder* (sic), where depression of a severe and recurrent nature is evident, involves clinical phenomena which are similar to 'reactive', or 'neurotic' depressions and may arise from either endogenous *or* exogenous causes. In a related vein, Tsaung *et al.* (1985) suggest that although it is common to assume an aetiological distinction between bi-polar and unipolar depressive illness, these share a common aetiology and are, respectively, mild and severe forms of the same disorder. They add, however, that in addition to the common aetiology:

> ...each disorder might involve a unique source which is responsible for their phenotypic differences. This unique source could be either genetic or environmental (Tsaung *et al.*, 1985).

As noted above, no common international classification system exists for the diagnosis of depressive illness. In an attempt to maintain consistency, against the background of clincial and research diagreement, the term *affective disorder* will be used throughout the thesis where reference to depressive illness *in general*, is appropriate. The term *manic depressive psychosis* will be used to refer

to patients who have been diagnosed as suffering from either recurrent depression or mania, alone or in combination and where the depression is primary: i.e. it exists independent of any other mental or physical illness or overt psychosocial precipitant, such as bereavement (Naylor, 1987).

Clinical features of depression. The presentation of *depression* in uni-polar and bi-polar disorder is indistinguishable, according to Shaw, Kellam and Mottram (1982).The patient's mood may range from mild sadness to profound melancholy. Mild to severe anxiety and apprehension is also a common accompaniement. Loss of appetite, often expressed by a loss of taste for food, leads to weight loss, although a small number of patients engage in food 'bingeing'. The patient is indifferent to usual interests and is often acutely aware of feelings of inertia, lack of motivation and physical tiredness. In severe cases, a general slowing of speech, thought and movement takes place, whereas in others anxiety, with accompanying displays of restlessness and agitation, may be seen. In either case, the patient finds it difficult to concentrate and even simple tasks involving decision-making and planning may be impossible due to the disruption of cognitive processes. Many patients also report emotional numbness, including an inability to feel for others, a deficit of which they are acutely aware. Variations in mood and other features is common, reflecting a disturbance of natural rhythmn, especially in the early stages of the illness. The patient may feel worst on awakening, gradually improving during the day. Sleep disruption is also evident but may be partly a function of dietary changes arising from the loss of appetite. Although depth and onset of

sleep may be affected, early morning wakening is the most prominent feature.

Psychological features also range in severity. Exaggerated feelings of worthlessness, guilt and hopelessness can extend through to delusions of guilt, poverty, punishment catastrophe and nihilism. Paranoid ideas and ideas of reference may also be present. Suicidal thoughts stem from feelings of hopelessness, with suicidal acts most common on entry to, or exit from, a deep depressive phase. [This clinical vignette is drawn from Shaw, Kellam and Mottram (1982)]

Clinical features of mania. The main characteristic of mania is an experience of euphoria. The patient feels a sense of heightened energy, well-being and enthusiasm. Speech is rapid and discursive, the patient often flitting from one subject to another in an amusing fashion. Pressure of thought and distractability, coupled with exaggerated activity, often results in a failure to follow through tasks to their completion. In 'hypomania', the patient may tax greatly those around him, by forceful and energetic organisation of the environment. As the mania heightens, grandiose schemes may be undertaken, incurring financial embarassment or disruption of the patient's affairs or those of his family. Need for sleep appears to decline, as more time is devoted to planning and executing increasingly grandiose schemes. At this level, the patient may also be sexually disinhibited and promiscuous. Exhaustion is the natural result of overactivity and diminishing self-care and can, on rare occasions, be fatal. In some patients, the mania alternates rapidly with depressive thought content

in a so-called 'mixed affective state'. Although the patient appears excited and overenthusiastic, questioning easily reveals an underlying depressed state, which gives a nightmarish quality to the patient's life. [This clinical vignette is drawn from Shaw, Kellam and Mottram (1982)]

Prevalence of affective disorder. Although depression has been studied closely for centuries and recognised even longer, no satisfactory or agreed classification of depressive illnesses is available (Reveley and Murray, 1984). As noted earlier, a number of classification systems exist, each defining, and subsequently measuring, slightly different phenomena. In their New Haven study, Weissman and Myers (1978) found a prevalence rate of 3.2 per cent for men and 5.2 per cent for women, using the Research Diagnostic Criteria categories of 'minor' and 'major depressive disorder' (Spitzer *et al.*, 1978). The Camberwell study of Bebbington *et al.* (1981) used an arbitrary cut-off for diagnosing depression from the Present State Examination (PSE) and identified prevalence rates of 4.8 per cent for men and 9.0 per cent for women. An Australian study using the PSE reported lower rates for both men and women; 2.6 and 6.7 per cent respectively (Henderson *et al.*, 1979). Despite these differences, studies consistently show a higher prevalence rate for women, of approximately 2:1. Prevalence studies are further confused by the indecision which exists concerning the dividing line between normal and pathological unhappiness, and the observation that population studies using questionnaires consistently show a higher prevalence of depression than do interview based data (Kendell, 1983b). Although the epidemiology of affective disorder is somewhat confused at

present, researchers are showing an increased use of structured interviewing techniques and less ambiguous diagnostic criteria which should clarify this situation in the near future. Jablensky (1987) notes that the World Health Organisation, which has a mandate for establishing international standards for biomedical research, may play an important role in removing the obstacles represented by conflicting classification systems.

A different appreciation of the scale of affective disorder can be gained from hospital admission, and re-admission, rates. In Scotland in 1984, affective psychosis (sic) accounted for 20.1 per cent of all women, and 11.2 per cent of all men, admitted to hospital. First admissions represented 12.6 per cent of all female and 7.8 per cent of all male patients; re-admission rates were considerably higher, at 24.5 per cent for women and 12. 4 per cent for men (see Information Services Division, 1986). These include the acknowledgement that women are more likely to report depressive symptoms than are men (Weissman and Paykel, 1974) and that psychiatrists are more likely to perceive depression in women than in men (Chesler, 1972). These hypotheses will be discussed further in a later chapter.

Aetiology of manic depressive psychosis. The characteristic mental disturbance of manic depressive psychosis is often correlated with a disturbance of biochemistry, and is assumed to be a biophysical disorder influenced by genetic transmission (Cadoret and Tanna, 1977; Mendels, Stern and Frazer, 1976). A wide range of psychological models have also been presented in an attempt to explain the genesis of more

severe depression, such as Jacobsen's (1954) combination of Freud's object relations theory with traditional ego psychology and drive theory; Cohen *et al.*'s (1954) analysis of the interpersonal and family context of manic depressive psychosis; Brown and Harris' (1978) interpretation of the social setting of depression; and Beck's (1970) emphasis of the role of 'thought disorder' in depression. Shaw, Kellam and Mottram (1982) emphasise that although affective disorder is likely to arise from a biological abnormality, this merely means that the core symptoms involve biological/physiological changes in the brain which, if reversed, would lead to rapid loss of the symptoms. They acknowledge that this in no way negates or devalues the importance of psychological factors, especially the role of life events. Such views seem to harken back to the 'psychobiological' model of Meyer (1908) noted earlier. Ariskal developed a 'biobehavioural' model of depression, which is the contemporary equivalent of Meyer's earlier concept. Ariskal (1979) suggests that:

> ...melancholia (sic) is the culmination of various etiologic factors that conceivably converge in areas of the diencephalon that modulate arousal, mood, motivation and psychomotor functions (p.430)

Depression, therefore, is a psychobiologic state that represents the final common pathway various processes, involving the interaction of physiological stressors, genetic predisposition, psychosocial stressors and developmental predisposition. The variation in the clinical expression of depression may result, in Ariskal's view, from the interactional patterns of two or more of these processes.

Medical *treatment and nursing care of patient suffering from manic depressive psychosis*

The treatment of the patient with manic depressive psychosis is, in principle, relatively straightforward. Manic attacks are commonly treated by drugs, and depression by an alternative range of drugs and electroplexy, which may or may not be supported by psychotherapy (see Clayton 1978 for review).

The role of nursing staff in caring for this population, at least in Great Britain, appears to have two major functions:

i) the expression of medical treatment: such as participation in diagnosis, giving medication, preparing patients for electroplexy.

ii) the provision of general support: for example helping the patient cope with everyday living during manic or depressed periods; providing security and reassurance.

Treatment outcome. Although attempts to identify the aetiology of manic depressive psychosis from a biophysical standpoint have shown encouraging results, the treatment of such patients is not entirely satisfactory. Although some patients respond well to medical intervention (especially to antidepressant therapy and lithium prophylaxis), many relapse. Bratfos and Haug (1968) reported that as many as 48% of patient studied suffered relapses, with 47% of patients following a chronic course. Welner (1977) was more optimistic, suggesting that chronicity (typified by presence of symptoms, social decline or both) occurred only in approximately one-third of bi-polar patients. Recent World Health Organisation data (WHO, 1979) indicated that two years after the index episode, 35% of patients recovered

without further relapse and 21% showed residual symptoms but no relapses. 37% of the patients had one or more relapses and 7% continued to be severely depressed, without remission from the initial episode.

Towards An Integrated Model Of Manic Depressive Psychosis

The psychosocial context of manic depressive psychosis. A formal model of psychotherapeutic intervention with manic-depressive patients was first introduced by Cohen and her colleagues at the Washington School of Psychiatry (Cohen *et al.*, 1954). Their elaboration of the interpersonal model of Harry Stack Sullivan challenged many of the traditional concepts of depression (e.g.the 'loss hypothesis': Freud, 1917). Instead, they focussed upon the relationship between the patient and significant others. More recently, there has been a resurgence of interest in psychotherapeutic work with unipolar and bipolar patients, in an attempt to improve the outcome of medical intervention. Mayo (1979) has suggested that lithium therapy should be combined with marital therapy, in view of the incidence of marital problems encountered by manic depressive patients, again emphasising the importance of interpersonal variables. The integration of these different theoretical perspective on the aetiology and treatment of manic depressive psychosis is also evident in Ariskal's (1979) 'biobehavioural' model, noted earlier.

Patients experiencing depressive or manic attacks have often been represented as 'interpersonally-isolated' systems. This reflects the view that all significant aetiological factors are 'internal' or endogenous; arising from a biophysical base. This view has been

challenged by, among others, Ludwig and Ables (1974) who argue that the patient may be highly susceptible to influence by 'significant others' such as spouse or nursing staff. They comment that:

> ...humans interacting with a biologically susceptible individual may exert considerable influence on the initiation, alteration and perpetuation of excessive affective states (p.419).

They go on to hypothesise that:

> ...at the level of maximum speculation this may imply mutual, non-verbal, subconscious "biochemical communication" between two intimate individuals can occur, not only altering their internal biological milieu but subtly altering their behaviour as well (Ludwig and Ables, 1974, p.419).

A similar view is expressed by Janowsky *et al.* (1974) in respect of the patient in a manic state. Contradicting an earlier conclusion that manic episodes were part of the patient's pre-morbid personality, Janowsky argued that flattery, limit-testing, exploitation of weak spots, provocation of anger and division of staff were restricted to the manic phase and could be managed by nurses.

The view that the problems of the patient with manic depressive psychosis might involve more than a straightforward dispruption of biochemistry has also been expressed by Ambelas (1979), who challenged the view that mania was *never* of psychogenic origin. Ambelas suggested that manic, as well as depressive, episodes could be precipitated by stressful events. Such a view has obvious implication for treatment. Whereas authors like Beck *et al.* (1980) have shown encouraging results with non-psychotic depressive disorder, others (for example Blue, 1978) have suggested, through single-case studies, that even manic patients may learn how to identify and cope with with 'mania-producing' situations.

The role of the patient

Although some researchers have acknowledged that manic and/or depressive episodes may be 'triggered' by stressful stimuli, little is known of the patient's view of these events. A number of scales have been developed and validated to measure anxiety, (Speilberger *et al.* 1970); depression (Beck *et al.*, 1961) and mania (Beigel *et al.*, 1971; Blackburn *et al.*, 1977). However no standardised format is in use which assesses the patient's attitude towards or understanding of 'illness'. It has been suggested that psychosocial stressors play a part in the genesis of affective psychosis and that patients can be helped to cope better with such stressors. Such an approach is, however, dependent upon the patient's appreciation that such external events do exist and play a part in the genesis and maintenance of her problems. If the patient does not believe that such events are important, or that she can influence them, then any offer of psychotherapy is likely to be of limited value. In this context, some patients emphasise their need for sensitive support as an alternative to medication (Campbell, 1983) or more formal psychotherapy (Hutchings, 1987), whereas others emphasise approval of medical treatment and a virtual rejection of traditional psychotherapy (Gray, 1983).

The Nurse's Primary Psychosocial Role.

Although nurses fulfill a significant medical-expressive role, their dealings with patients are primarily psychosocial in nature. This view of psychiatric nursing will be discussed further in subsequent chapters. In any nursing situation, the nurse is required to assess the patient in both physical and psychological terms. In a number of

situations it is important to assess the patient's knowledge about her condition and beliefs about the cause and current treatment of her illness. These views may be crucial to the outcome of treatment, especially where the patient is required to collaborate in treatment to any degree, or where there is a history of non-compliance (see Barker, 1986). The significance of the patient's views becomes even greater where the nurse is concerned to offer some form of 'self-help' programme to the patient: such as identifying exercise or dietary needs.

A number of measures are available for the assessment of the patient's knowledge about the aetiology, care and treatment of diabetes (Bowen *et al.*, 1961); beliefs and feeling about illness in general (Jenkins, 1964); and the patient's perception of 'powerlessness' in illness (Roy, 1976). As already noted, it may be of value to be able to assess the beliefs which the patient with manic depressive psychosis has about herself and her illness. Such attributions may be important to the design of a system of nursing care.

Overview of the Study

Manic depressive psychosis is understood generally to involve a disruption of biophysical functioning which is most likely transmitted genetically. Acknowledgement is, however, given increasingly to the possible role of environmental factors in the precipitation of manic or depressive episodes. Some authors assert that *most* psychiatrists work from the assumption that environment and constitution combine to interact in the aetiology of mood disorders (Shaw, Kellam and Mottram,

1982). However, little is known of the patient's understanding of the condition and the part played by such understanding care and treatment. If psychosocial stressors play even a small part in the genesis of affective psychosis, and if patients can learn to cope with such stressors, this may help reduce the severity of individual attacks and possible relapses.

With such considerations in mind, a study was designed which aimed to evaluate the effect of specific forms of nursing intervention on patients suffering from manic depressive psychosis. The study focussed exclusively upon women sufferers, presenting as depressed at the time of the study. This decision was influenced in part by the majority status of women in the prevalence of affective disorder in general and partly by the orientation of the service unit used as the base for the study, which catered exclusively for women. In pursuit of the overall aim of the study, the following research questions were delineated:

1. What kind of role does the nursing literature describe in relation to the nursing care of patients suffering from affective disorder in general and manic depressive psychosis in particular?
2. What are the explicit and implicit objectives of the Registered Mental Nurse training programme in relation to care of the patient with affective disorder and manic depressive psychosis?
3. How do practising nurses perceive their role when caring for the patient with affective disorder in general and manic depressive psychosis in particular?

4. How does the patient suffering from manic depressive psychosis perceive herself in relation to her condition or illness?

5. What effect do specific forms of nursing intervention have upon the manic depressive patient's perception of herself in relation to her condition?

6. What effect do these forms of nursing have upon other measures of the manic depressive patient's pathological state?

7. Do manic depressive patients perceive any differences between the different kinds of nursing intervention offered and the roles of the nurses involved in the delivery of their care?

Overview of Research Design

An overview of the study is provided in Figure 1.1. The three main phases of the study are represented in the three 'parts' of the thesis.

Figure 1.1 : Overview of Research Design

Aim	Method
Definition of routine nursing care: questions 1 - 3.	Part One : Chapters 2 - 7 Literature review Analysis of training syllabus: sub-studies 1 and 2. Descriptive studies of nurses' perceived role : sub-studies 3 and 4.
Development and field trial of dependent measure: question 4.	Part Two: Chapters 8 - 12. Descriptive study of 'locus of control' construct in 'acute' and 'recovered' patients: sub-studies 5,6.
Evaluation of effects of specific nursing interventions: questions 5,6 and 7.	Part Three: Chapters 13 - 17. Experimental study of care of women with manic depressive psychosis: the main study.

PART ONE

CHAPTER 2

INTRODUCTION AND OVERVIEW TO PART ONE

In Part One of the thesis three questions are addressed, each representing an attempt to clarify the specific *nature* and *function* of the nursing care of patients diagnosed as suffering from manic depressive psychosis.

1. What kind of role does the nursing literature describe in relation to the care of patients suffering from affective disorder in general and manic depressive psychosis in particular ?

Manic depressive psychosis is only one of a number of diagnoses embraced by the 'umbrella' title *affective disorder* (or illness). As noted in Chapter 1, the definition and diagnosis of all depressive disorders, including manic depressive psychosis, is an inexact science, with a number of different diagnostic or nosological classifications used worldwide to describe the same phenomena. In consideration of this fact, it would be inadvisable to study only the nursing literature which made specific reference to manic depressive psychosis. Instead, prescriptive and descriptive literature, which addressed the care of any form of affective disorder, was reviewed in an effort to describe the nurse's role in caring for depressed people, in general, and people suffering from manic depressive psychosis in particular.

The nursing care of patients suffering from affective disorder represents only one, albeit sizeable, area of psychiatric nursing. It was assumed that some principles of nursing care, which are relevant to patients in general, would apply also to the care of this specific psychiatric sub-population. Consequently, it was decided to preface the review of this area of nursing care, with an appraisal of more general considerations about the nature and function of psychiatric nursing.

In Chapter 3, an overview is provided of the conceptual basis of nursing in general and of psychiatric nursing in particular. This is followed, in Chapter 4, by a review of the psychiatric nursing literature in relation to affective disorder in general and manic depressive psychosis in particular.

2. What are the explicit and implicit objectives of the Registered Mental Nurse training programme in relation to the care of the patient with affective disorder in general and manic depressive psychosis in particular?

The General Nursing Council for Scotland (G.N.C. Scotland) was constituted in 1919 to establish and maintain a register of nurses. In 1978 the G.N.C.Scotland noted that:

> ...one of the main functions of the Council is to ensure that all nurses it registers or enrols have received a training that makes them competent to provide safe and skillful care (G.N.C.Scotland, 1978,p.1).

The Council acknowledged a duty to prescribe the form that should be taken by any scheme of training that leads to registration or

enrolment, amending these requirments from time to time in the light of changing conceptions or circumstances of nursing. In an attempt to assess the Council's values regarding safe and skillful care in relation to care of the patient suffering from affective disorder in general and manic depressive psychosis in particular, the most recent prescribed format for Registered Mental Nurse (RMN) training, from the G.N.C. Scotland, was examined (G.N.C. Scotland, 1978). This involved an appraisal of those parts of the *sample curriculum* for RMN training which specified the nursing care of patients with any form of affective disorder and an appraisal of *final examination questions* which specified the nursing care of patients with manic depressive psychosis in particular. The appraisal of the sample curriculum is described as *Sub-study 1* and the appraisal of the accompanying examination questions is described as *Sub-study 2*. Both sub-studies are presented in Chapter 5.

3. How do practising nurses perceive their role when caring for the patient with affective disorder in general and manic depressive psychosis in particular?

It could be hypothesised that nursing practice might differ significantly from the prescriptions and descriptions in the nursing literature and the role expectations implicit in the nurse training programme and examination. In an attempt to describe nurses' view of their 'routine' role, two further sub-studies were undertaken. In the first (sub-study 3), the nursing team which was to participate in the

main study reported in Part Three of the thesis, provided data on their perceptions of care of women with manic depressive psychosis. In the second sub-study (sub-study 4), a sample of Scottish nurses provided descriptions of their role in relation to patients suffering from affective disorder in general. These two sub-studies are reported in Chapter 6.

The aim of the main study, reported in Part Three, was to evaluate the effect of specific nursing interventions in the care of patients with manic depressive psychosis. This study compared *traditional*, or 'routine nursing care', with two alternative forms of nursing intervention. The definition of 'traditional', or 'routine', care was based upon data drawn from the review of the psychiatric nursing literature and the two nurse sub-studies. These data were amplified by more general considerations of the nature and content of 'care', deriving from the historical roots of psychiatric nursing in general. In view of potential differences between psychiatric nurses trained, and/or practising, in Scotland and elsewhere in Great Britain, 'routine nursing care' was defined primarily by the reported activities of Scottish nurses.

CHAPTER 3

THE CONCEPTUAL BASIS OF NURSING

The Nightingale Heritage

The concept of *nursing care* is not easily defined. Typically, it is expressed in terms of the *practice of nursing*. The common thread of most definitions embraces the concept of caring for, tending, promoting or fostering growth. These stem from the old French '*norice*' and the late Latin '*nutrire*', both meaning '*to nourish*'. Although an association with tending the sick and dying or the rearing of children is very strong, the term can also represent 'a tree planted to protect another during growth'[forestry], or even the 'action used to keep the balls in a good position for cannons'[billiards]. The definition of nursing in a professional sense is not, however, quite so clear. Contemporary meanings have been influenced greatly by the concept of modern nursing developed by Florence Nightingale. Most dictionaries refer to "a person trained to care for the sick or infirm *under the direction of a doctor*" (Watson, 1976: emphasis added). It is accepted generally that this role as the 'doctor's assistant' derives from Nightingale. Austin (1977) and Dingwall (1979) both have suggested that the 'style' of Nightingale nursing developed as a reflection of Victorian middle class family life. Doctors symbolised patriarchal authority over women and women's work. Many nurses doubt whether such a subordinate role can ever be called *professional*. Cohen (1981) argues that Nightingale's model has had a profound effect not only upon the practice of nursing, but upon how nurses see themselves:

> ...if one examines the professional self-concept in the Nightingale tradition, the root of the problem is easy to see. Nightingale defined the nursing role as handmaiden to the physician, and it has remained so. Handmaidens are not professionals (Cohen, 1981, p.140).

Such a critique of the traditional role is hardly new. For more than a decade there have been calls for nursing to "free itself from the tradition of obedience and subservience"(Group and Roberts, 1974); influences which these authors saw as the "ghosts of the Crimea".

The promotion of health.

Nightingale's concept of 'modern nursing' extended the traditional meaning, by the addition of emphasis upon a vocational base. This appears to have been a reflection of her own religious conviction. She was committed to the service of her fellow man: nursing being a way to express such committment. She appears to have had little faith in the direct therapeutic potential of nursing care itself. Instead, she saw the act of nursing as "putting the patient in the best condition for nature to act upon him" (Nightingale, 1969,p.133) It may be concluded that by 'nature' she included the intervention of God. As noted already, the term is associated commonly with the care of the sick or dying.

Holistic care. Nightingale, however, embraced a much broader philosophy which her successors have tried to preserve against erosion by time and the popular 'Crimean model'. Henderson and Nite (1978),for example, note that Nightingale saw nursing as *helping people to live.* She saw body and soul as inseperable, and looked upon the patient as a member of a family and community. Nursing, therefore, was an expression of

citizenship and religion. Interest in the patient as a 'whole person', in this Nightingale sense, has experienced something of a renaissance recently, even to the extent of a specific focus upon the spiritual status of the patient (Simsen, 1986). Henderson and Nite (1978) developed the 'modern' version of the Nightingale nursing model with a definition which addresses *people,* whether ill or not. They suggested that the unique function of the nurse was:

> ...to help people, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will or knowledge. It is likewise the function of nurses to help people gain independence as rapidly as possible (Henderson and Nite, 1978, p.34).

The emphasis upon the development of independence, and the promotion of health, however defined, reunites nursing with its root definition, and breaks the bond, so to speak, of the the concept of the nurse as a' ministering angel' with an interest only in the alleviation of sickness. Such a definition is not, however, without its problems. It appears to embrace virtually the whole of human experience; all of of which, it could be argued, play a part in the promotion or recovery of 'health'. Such a definition also blurs the borders of the nurse's role even further, merging her work with other professions. Apart from doctors, clinical psychologists, teachers, social workers, various 'therapists', even ministers of religion, might see their vocation expressed in similar terms.

A quasi-anthropological perspective

The concept of the vocation of nursing is much older than Nightingale. Colliere (1986) reminds us that *care* serves a basic survival function

in any community, or indeed within any species. This function is (or was) principally a female vocation. This basic caring or *mothering* role involved the promotion of growth and development both of children and the plants which served as an integral part of their diet. Colliere was drawing obvious parallels between the 'nourishing' role of mothers and gardeners. A similar parallel was made earlier by Barker (1986) where a comparison was made between the practices of the nurse and the nurseryman. Colliere also noted that women helped the sick and dying, though rarely those wounded in combat, who were cared for by men. In her view, women also played a primary role in the development of pharmacology, through their work with plants, and consequently in the development of medicine. With the development of writing and its exclusive use by priests:

> ...men started to confiscate women's knowledge, transferring what they could collect from them, and assimilating it for their own understanding (Colliere, 1986, p.98).

Religious roots. Colliere argues further that Christianity served as the key influence on modern nursing by the institutionalisation of care under nuns. The attitude of the Catholic church towards the sexuality of nuns (the "consecrated virgins"), and their servile status, played a major role in generating the "invisible role" subsequently adopted by nurses of the post-Nightingale period. Colliere's thesis serves as a contrast to the views of Dingwall and Austin noted earlier, which locate the origins of nurses dependent status firmly within the grip of Victorian values. This quasi-anthropological perspective reminds us of the Roman Catholic Church's influence upon our modern concept of nursing. Indeed, nurses continue to dress in a thinly disguised version

of the nun's habit. More importantly, Colliere's thesis serves as a reminder of the roots of nursing, in both a cultural and linguistic sense. The nurse's political subservience to doctors is a mirror image of the nun-priest relationship. The pervasive philosophy of nursing also is influenced strongly by values stemming from a religious base. Although Colliere, Henderson and even Nightingale assert strongly the place of nursing, in the care of both the 'sick' and the 'well', the concept of ministering unto the sick is the most popular meaning. In modern times this has led to questions concerning the 'need' for nurses in certain traditional care areas; the most obvious example being the debate concerning the 'care' of people with a mental handicap (Department of Health and Social Security, 1979).

The Origins of Psychiatric Nursing

These observations about nursing in general are important also to the understanding of psychiatric nursing. People with mental disorder have been the recipients of various forms of care down the ages. By virtue of their strength, men were more prominent in the *care* of the mentally disordered, who often needed forcible containment. This role paralled the 'male nursing' role which had developed in lazarets, where men cared for those with contagious diseases, often at sea; and where they dealt with the consequences of battle. Men's association with psychiatric nursing possibly has its roots in the work of Joao Cuidad (1495-1550), who set up a shelter for mentally ill people and social outcasts in Portugal. Cuidad's vocation was influenced by his own experience of confinement as a lunatic, having had what appeared to be

a manic episode following his religious conversion. He was later to be canonised 'John of God', becoming the figurehead for the order of the same name which continued his vocational work with the poor sick, which included the mentally disordered (Cross and Livingstone, 1983). The influence of the Roman Catholic Church was also shown through the work of St Vincent de Paul (1581-1660) who turned a leper hospital at St Lazare in southern France into that country's first asylum.

Development of the care system

Although various asylums had been present in England since the 12th century, their importance grew with the influence of the intellectual tradition of the 'enlightenment' in the late 17th Century (Locke, 1964). Britain led the world in the creation of more humanitarian care settings, embraced by the emerging science of medicine. Religious views, however, also played a significant role in the development of the enlightened view of the British asylum tradition. William Tuke, who founded the Retreat at York in 1792, was one of the foremost pioneers of the 'moral treatment' approach which tried to turn asylums into more humane 'havens' for the mentally disordered. It has been suggested, however, that the principles of Tuke's approach were:

> ...based not on the scanty medical knowledge of the time, but on Christianity and common sense (Bockoven, 1963, p.45).

Early training initiatives. The asylum attendants of this period represented the first official care agents, and were the predecessors of the psychiatric nurse. John Haslam (1764-1844), Apothecary to the Bethlem Asylum, was, in 1817, one of the first to propose that these

attendants should be given some kind of formal training (cited by Leigh, 1961). The first recorded staff training exercise was a short course of five lectures delivered by William Browne at the Royal Montrose Lunatic Asylum in 1834 on "what asylums were, are and ought to be." When Browne was appointed later to the Crichton Institution in Dumfries, he extended this to 30 lectures given to both male and female attendants in the period 1854-5. Browne's contemporary, Sir Alexander Morrison, had already begun a formal course of instruction for attendants in 1843 at the Surrey Asylum, later to become Springfield Hospital (see Walk, 1961). This served as the stimulus for the spread of similar courses of instruction which culminated in 1885 in the preperation of 'the red handbook': the *Handbook for the Instruction of Attendants on the Insane*, by the Royal Medico-Psychological Association (RMPA). By 1889, one hundred hospitals had participated in training programmes based on the handbook and in 1890 the RMPA instituted the first register for attendants, who had completed successfully a two-year training (Walk, 1961). The formal concept of psychiatric nursing, represented by a qualification and register is, therefore, less than one hundred years old. The United States of America followed a similar path, formalising their training arrangements in 1906 under the aegis of the American Medico-Psychological Association.

Psychiatric nursing emerged, therefore, from the patronage of the medical profession at a time when philanthropy was much in vogue. It is clear that most of the nursing developments of the past century have continued to depend upon the benificence of psychiatrists and the development of psychiatric medicine. Not until the beginning of the

second half of the twentieth-entury did psychology and sociology begin to make their own important influences on the knowledge base of nursing - influences which were to prove useful in helping nursing see itself in more objective relief (Skevington, 1984). However, despite such recent developments, the concept of psychiatric nursing in Britain remains an insecure, if not hazy, concept.

Refinement of the concept of psychiatric nursing. Confusion and conflict over its conceptual base is evident in nursing in general and is not exclusive to psychiatric nursing. In the wake of interest in the process of nursing, various conceptual models have been described (Kershaw and Savage, 1986; Pearson and Vaughan, 1986; Riehl and Roy, 1980; Wright, 1986). Although some authors have attempted to relate these conceptual models to the practice of psychiatric nursing (Barber, 1986), their value has not been demonstrated in research terms, and some nurses have expressed reservations about the actual contribution to care made by nurses' nuse of such 'generic nursing' models (Drummond, 1985). Confusion also exists over the definition of the nurse's role (Cormack, 1983). The last decade has seen major changes in nursing education, with the acceptance of the need for a research basis for nursing practice (Department of Health and Social Security, 1972) and the generalisation of interest in the 'process of nursing' (Scottish National Nursing and Midwifery Consultative Committe, 1976). The impact of these changes has been felt most strongly in general nursing. Davis's (1986) review of recent research in psychiatric nursing illustrates that very little *clinical* research has been generated in the United Kingdom, even in the period 1980-84. His review

shows that most research deals with the education of the nurse or general features of the nurse's role. Also, some commentators consider the person-centred model of the nursing process to be incompatible with psychiatric practice, suggesting instead more emphasis upon a *systems* approach (Altschul, 1978). Other psychiatric nurses have been more optimistic about the potential value of the process of nursing, seeing an opportunity for nurses to make their own statements about care. In this context Bradshaw has written:

> ...nurses are raising issues about the conceptual framework of psychiatry and asking important questions about the behaviour which psychiatrists have purported to explain for so long' (Bradshaw, 1986, p.34).

The Interpersonal Roots of Psychiatric Nursing

For much of nursing's history, the concept of care has been shrouded in confusion. The layman might be forgiven for assuming that care is about 'looking after' and is to be distinguished from *treatment*, which signifies a more productive interaction with the patient. Such a distinction appears to be evident even at the highest level of the profession. The conflict between those nurses who see themselves as carers, in a purely supportive sense, and those who attribute a therapeutic dimension to their work, has been highlighted recently by Vousden (1986). Connolly (1856) appears to have been one of the first to recognise the therapeutic, as well as damaging, potential of attendants in the Victorian asylum, noting that:

> ...all his (the physician's) plans, all his care, all his personal labour, must be counteracted, if he has attendants who will not observe his rules (p. 37).

Seminal influences

The doctor's need for adequate and effective support in his absence played a significant part in the formalisation of training of attendants and subsequently nurses. Viewed from this perspective, the clarification of the psychiatric nurse's role appeared to be an expedient way of ensuring the quality of *medical* treatment. Indeed, for most of its history, psychiatric nursing has continued to stand in the ideological shadow of psychiatric medicine, functioning mainly as a medical support system (see Cormack, 1976). However, Connolly's recognition of the importance of nurses as *providers* of care (and the medium of medical treatment), also represents the first formal acknowledgement of the *interpersonal* basis of psychiatric nursing.

Psychosocial models. The medical, or clinical-somatic, model of psychiatry has been the governing influence on policies of care of the mentally disordered (Ramon, 1985). From the early experiments with water-torture and flogging, to today's invasive treatments with drugs and ECT, care and treatment has reflected the practice of the physician. This orientation has been challenged at various points in the history of psychiatric care and treatment. The most outstanding alternative came from the psychoanalytic movement which proposed a psychological, as opposed to physical, model of mental disorder. This development made little impact on nursing practice in Great Britain, where this model of treatment was restricted to a very small minority of the patient population. The first serious alternative to the medical model of psychiatry came in the form of the therapeutic community movement of the late 1950's and early 1960's (Jones, 1968). Many nurses

became involved in this *social* model of psychiatry, although their work focussed mainly upon the so-called 'neurotic' patient population (Barnes, 1968). The next significant alternative came in the form of the psychological treatment model which grew out of modern behaviourism. Behavioural *psychotherapy*, described by Marks and his colleagues, emphasised the selection of certain 'neurotic' patients considered amenable to this form of therapy (Marks *et al.*, 1977). Behavioural *rehabilitation*, which was geared towards the more chronic psychiatric patient population, emphasised a different set of psychological principles, and a slightly different range of therapeutic methods (Butler and Rosenthal, 1978). 'Behaviour therapy nursing', was more eclectic in its attempt to outline a model of nursing appropriate to almost all patient populations and problems (Barker, 1982; Barker and Fraser, 1985; Barker and Wilson, 1985).

The experience of the nurse in the U.S.A. Soon after the end of the Second World War, some nurses in the United States of America, who had trained within the psychodynamic movement, began to develop a psychotherapeutic model of psychiatric nursing (Mereness and Taylor, 1978; Peplau, 1952). Although some of these nurses stayed within the dominant culture of psychoanalytic thought, others, such as Peplau (1952), transferred their allegiance to the interpersonal school, influenced by the work of Harry Stack Sullivan. Psychiatry, in Sullivan's view, was not restricted to the study of mentally ill people, or even of processes, successful and unsuccessful, which may be observed in groups. Instead Sullivan saw psychiatry as:

> ...the study of processes that involve or go on between people. The field of psychiatry is the field of interpersonal relations, under any and all circumstances in which these relations exist... a personality can never be isolated from the complex of interpersonal relations in which the person lives and has his being (Sullivan, 1947, p.4).

This alternative conceptualisation of psychodynamic thought won favour with many nurses who saw within this model a theoretical perspective which could be related directly to the interpersonal world of nurse and patient. The move away from traditional psychotherapy was reinforced further by the influence of the humanistic psychology movement (Rogers, 1951) which also eschewed emphasis of intrapsychic explanations. Although contemporary psychiatric medicine in the United States of America is influenced strongly by a biophysical model, psychiatric nursing appears to have moved further and further away from such an orientation in favour of an extension of the interpersonal model (Peplau, 1986).

Contemporary ambitions. Nursing developments within the United Kingdom over the past two decades, combined with vicarious experience of psychiatric nursing culture in the U.S.A., have lent support to an interpersonal model of British psychiatric nursing. Although close observeration suggests that custodial or medical-expressive roles continue to dominate psychiatric nursing (Armitage, 1986; Cormack, 1976; Towell, 1975) it has become common practice to *assert* the interpersonal basis of psychiatric nursing. In anticipation of major reform of all forms of nurse training (United Kingdom Central Council for Nursing and Midwifery, 1987), the Joint Committee of Mental Health Nursing Organisations stated that psychiatric nursing operates within "a

conceptual framework of social psychiatry" and that the nurse's role is characterised by:

> ...a synthesis of knowledge built up from medicine, social and behavioural sciences, physiological sciences and skills training (JCMHNO, 1986,p.3).

That group saw the client (*sic*) population (the mentally disordered) as "outside the parameters of general medicine" and believed that nursing's "ideological framework (existed) within social rather than medical models of psychiatry" (JCMHNO, 1986,p.4).

The Psychiatric Nurses Association-Scotland (1986) articulated a similar set of views:

> ...mental (*sic*) nursing is clearly based on the social model of psychiatry within which interpersonal skills, used within systematic strategies, are central to their role' (PNAS, 1986,p.3).

This group suggest that the role of the mental nurse:

> ...operates on a social model in which the emphasis is on patient/client self help...regardless of whether nurses work under a traditional medical model or social model they constitute the most important influence in the patient's social environment' (PNAS, 1986,p.34).

It is not clear, however, whether the use of terms such as 'interpersonal' and 'social', as used by both these groups, reflect the same meanings originally articulated by Sullivan or later field theorists such as Lewin (1951).

Nurse-patient relationships. Interest in the interpersonal basis of psychiatric nursing in Britain can be traced back to the series of searching questions asked by Altschul as a result of her enquiry into nurse-patient interaction (Altschul, 1972). She was interested in defining the theoretical basis of *sound* nursing practice and wanted to

know what kind of training nurses received to help them form relationships with patients. More than a decade later she was still uncertain of the answers to these questions (Altschul, 1984).

One of the key studies of psychiatric nursing undertaken in Britain (Towell, 1975) concluded that the term 'psychiatric nurse' encompassed a cluster of roles, which varied according to the setting. Contrary to the 'interpersonal view' expressed above, Towell, a sociologist, noted that the formation of personal relationships which is emphasised in the literature, was a limited feature of the nurse's role.

The view from the nursing literature

Cormack (1983) observed that the nurse's role can be defined in terms of suggestions as to what nurses *should* do (the prescriptive literature) and observations of what nurses do *in practice* (the descriptive literature). A number of roles within Cormack's prescriptive category are paraphrased below.

The supportive role. The nurse's traditional role as a support to medical staff stems from the work of asylum attendants noted above. Belknap (1956) suggested that nurses *mediate* between doctors and patients, preventing the doctor from being overwhelmed by the demands of the patient group. A similar view was expressed more recently by the nurse/sociologist Colledge (1973). The 'expressive' role described by Johnson and Martin (1958) is perhaps the most significant description of the subordinate position of nursing. They saw medical staff as 'instrumental' in the sense that they "moved the care system towards

its goal" whereas nurses expressed the work of doctors by "maintaining the motivational equilibrium within the individual"(Johnson & Martin, 1958,p373). This led to the popularisation of the term 'medical-expressive role' as a description of those nursing activities which expedited medical treatment, such as giving injections or dispensing medication.

The social role. Various groups and individuals have suggested that, since nurses exercise a range of specific technical, interpersonal and social skills, their role is multidimensional in character (see World Health Organisation, 1957). More recently, James (1972) noted the demanding nature of the range of tasks evident in many traditional institutional settings: clinician, educator, adminstrator, social worker, innovator, clerk and domestic help. The development of the therapeutic community movement of the late 1940's brought the nurse's role as a sociotherapeutic agent into sharper focus (Jones, 1968). Altschul suggested that:

> ...the special role of the nurse is to create a wholesome ward atmosphere and to influence routine and surroundings in the patient's interest (Altschul, 1963,p.123).

That approach required nurses to relinquish their traditional supportive, mothering, role for a *partnership* role which involved patient, doctor, nurse, and family if not the whole hospital community (Barnes, 1968). Elements of that role remain, but formal interest in the therapeutic community ethos has waned since the early 1970's (Morton and Tibits, 1970). In part, this may have been due to lack of formal training opportunities for that kind of work (Campbell, 1979)

but may also be a reflection of the gradual demise of the large institution.

The psychotherapeutic role. British psychiatry has been characterised by a broad eclectic base, where medical, psychological and social forms of treatment co-exist. Various schools of psychological treatment have prospered in Britain but have never commanded the kind of following which traditional psychotherapy gained in the United States. Although care in the State hospitals in the U.S.A. remained largely custodial in nature, many American nurses developed a formal psychotherapeutic role following training with various psychoanalytic foundations. As noted earlier, neo-Freudian psychodynamic psychotherapy (Brown & Fowler, 1971) was largely replaced by a broader psychotherapeutic model which emphasised interpersonal factors. Peplau (1952) was among the first to describe a psychotherapeutic role for nurses, an idea which was soon taken up by others (Kalkmann, 1958). Later, Peplau was to emphasise a "counselling or psychotherapeutic sub-role" as distinct from a formal "deep psychotherapy" intervention (Peplau ,1962), a concept which has gained considerable international support.

A 'psychotherapeutic role' is conceptualised here as one involving specific, *individual*, nurse-patient interactions, within a clear theoretical model. The psychotherapeutic potential of nurses has been proposed for at least the last twenty-five years (General Nursing Council for Scotland, 1962). However, if published reports are used as a measure of the realisation of such potential, the demonstration of a psychotherapeutic nursing role is a fairly recent innovation. In the

early 1970's, the behavioural psychotherapy movement projected a formal therapeutic role for nurses through specific training programmes (Marks *et al.*, 1978; McPherson *et al.*, 1978) involving the treatment of *neurotic* patients (Marks *et al.*, 1978); and the rehabilitation of long-stay patients (Fraser *et al.*, 1976). Others have emphasised the value of alternative psychotherapeutic models. Faugier (1985; Faugier and Reilly, 1986) described a psychodynamic model which was not 'traditional' in the analytic sense, whereas the supporters of gestalt counselling recognise the 'alternative therapy' status of their approach, and the limitations subsequently imposed upon practitioners (Kenny, 1986).

Although many writers have emphasised the 'therapeutic' potential of nurses, or have described aspects of the nurse's role as psychotherapeutic, the meaning of such terms can be questioned. Indeed, almost any interaction between two or more people might be described as psychotherapy. At present, no commonly accepted definition of the terms 'therapeutic' or 'psychotherapeutic', appears to exist within psychiatric nursing. Strupp's definition of psychotherapy as:

> ...the *systematic* use of a human relationship to effect enduring changes in a person's cognition, feelings and behaviour (Strupp, 1986)

might prove helpful to psychiatric nurses wishing to distinguish between helping, yet casual, interactions and those meetings with the patient which might, properly, be described as psychotherapeutic.

CHAPTER 4
NURSING CARE OF THE PATIENT WITH AFFECTIVE DISORDER :
A REVIEW OF THE LITERATURE

As described in the previous chapter, the role of nurses can be defined from an analysis of their *prescribed* role and their *actual* practice (Cormack, 1983). The consideration of the nursing literature on care of patients with affective disorder which follows distinguishes between these two classes of role definition.

The Prescriptive Literature

No single text book of psychiatric nursing is recommended reading for all psychiatric nurses in training in Scotland (Drummond, 1985b). A number of texts have, however, been used as 'suggested readings' over the past two decades. This section reviews these texts in an effort to outline the background literature to Registered Mental Nurse training programmes in Scottish Colleges of Nursing in recent years (Barker, 1986).

The traditional viewpoint

The influence of traditional psychodynamic theory can be found in some early textbooks. Beccle (1962), for instance, suggested that the cause of chronic depression was:

> ...to be found in the excessive force exerted by the conscience...the self thus belittled is made to feel guilty and remorseful. To explain these feelings the patient rationalises them into delusions of unworthiness (Beccle, 1962, p.171).

In Beccle's view, nursing care of such a patient involved close supervision tantamount to "policing"(p.172). As soon as the patient's mental condition permitted, the nurse was advised that:

> ...endeavours should be made to arouse interest in the surroundings by means of games and work of a simple character (p.173).

Bray and Bird (1964) suggested that the nurse should be ready to listen and give reassurance: "the patient's distress requires a quiet, positive, sympathetic attitude"(p.187). Beyond this generalised supportive role, the nurse was advised to provide occupational therapy and recreation and to attend to the patient's physical care, nutritional and sleep problems. When the patient was identified as being in 'rehabilitation', it was suggested that he "should be encouraged to discuss his difficulties with the Psychiatric Social Worker [*sic*]"(Bray & Bird, 1964,p.190).

The medical-expressive role. A similar 'protective and reassuring' role was advocated by Fowlie and Stokes (1972) against a background of overtly medical treatment, comprising drug therapy and physical methods. Emphasising the implicit interpersonal nature of care the nurse was advised:

> ...if possible [to] divert the patient's recall and ruminations from the morbidly unhappy themes associated with the illness, on to the successes of the patient's life (Fowlie & Stokes, 1972,p.184).

In a similar vein, Sheehan (1973) noted that routine interactions, such as washing or feeding, can be used to facilitate rapport building:

> To make contact is perhaps the most difficult part of the task, but once this is done progress is often steady (p.266).

These quotes illustrate the clinical-somatic or medical model of affective disorder, which pervaded the prescriptive literature of the 1960's and early 1970's. This influence is reflected still in many nursing text books. When doctors 'prescribe' nursing care when writing for nursing journals, they describe the syndromes of depression and associated treatments (Watts, 1978: a,b & c) or provide anecdotal accounts of the treatment of individual cases (Martin, 1976 & 1980). The concept of treatment in these reports is restricted to an emphasis of drugs, ECT and other forms of physical treatment, even when reported by nurses (Bhanjii, 1977). The description of formal psychological therapies by doctors in the nursing literature is rare (Pullen, 1979). A recent discussion of depression in women from a psychosocial perspective, by medical students, represents an unusual departure for medical articles in the nursing journals (Hopkins and Kumar, 1985). The latter authors apart, medical writers in nursing journals tend to eschew any theoretical rationale in support of their orientation to care and treatment.

The Caring Rationale. Aside from descriptions of basic care the nursing literature reflects specific ideologies of mental disorder. For instance, Burr and Andrews (1981) suggest that:

> Depression sometimes overtakes a person for no obvious reason at all. If this kind of depression develops into a *mental illness* [*sic*] it is called an *endogenous* depression, meaning one which comes from within the person himself, not from outside' (Burr & Andrews, 1981, p.150: italics added).

The recommended nursing intervention which derives from this viewpoint is basic care and support:

> Try not to let the depressed patient lie on his bed all day, keep him up and dressed and if possible get him out of doors for a walk.

> Exercise will help him, but he will feel the cold, so see that he has something warm to put on in bad weather (Burr and Andrews, 1981, p.151).

The likelihood that the patient may not respond to the nurse's attempts at interaction is, however, noted:

> Sit beside him when you can. Putting your hand over his or drawing his arm through yours as you sit or walk tells him of your concern. Use your eyes, your hands and your smile to show your sympathy [*sic*] (Burr and Andrews, 1981, p.151)

The emphasis upon emotional support is reinforced by Darcy (1984) who suggests that the act of:

> ...remaining with the patient gives him emotional support though outwardly he may not show this by his lack of interest and uncommunicativeness (Darcy, 1984, p126).

A simplified theoretical rationale for this kind of nurse-patient relationship is also provided in the recommendation that the nurse give of her:

> ...time, attention and sympathy [*sic*] *as it* reassures him in his basic need for acceptance and approval' (Darcy, 1984, p.126).

The nurse's use of self is strongly recommended, taking time just to sit with the patient. In Darcy's view, merely listening to the patient as he talks about the hopelessness and despair he experiences as he contemplates each new day "can be therapeutic" (Darcy, 1984, p.126). In a later description of a care plan for a depressed patient, the same author adopts the analogue of a medical prescription by suggesting that the nurse should 'reassure *as required*' (Darcy, 1985, p.29 : emphasis added). Another rationale for the use of reassurance is provided by Trick and Obcarskas who noted that:

> ...reassurance should be given, however often it is sought for....for refusal or rejection will confirm the patient's worst fears ' (Trick and Obcarskas, 1982, p.58).

Implicit Support. Other writers have reinforced the conviction that non-verbal communication of a caring attitude is a critical therapeutic factor. Mitchell (1986) is a strong advocate of this idea:

> Often it is the nurse's ability merely to convey to the patient that he is valued and that his recovery is important to her, will make the greatest impression (Mitchell, 1986, p. 197).

Altschul's basic primer of psychiatric nursing has been a popular text in Britain for many years. In the most recent edition, the value of the nurse patient relationship is emphasised by the acknowledgement that:

> The only comfort that can be given to the patient is empathy, interest and the appreciation of his mood' (Altschul and McGovern, 1985, p. 159).

Advice as to *what* the nurse might actually do in her interaction with the patient has been stated more sparingly by some authors. Priest and Woolfson (1980), for instance, point out the usefulness of 'just being there' (Priest and Woolfson, 1980, p. 177). None of the authors noted above make specific reference to published research, nursing or otherwise, in support their recommended interventions. No clear acknowledgement of the influence of any figure, movement or ideology, in the development of their care prescriptions is evident, although the existence of such influences is assumed. For instance, Altschul and McGovern state that:

> the physical presence of the nurse may be *sufficient* by itself during the acute phase (Altschul and McGovern, 1985: emphasis added).

Although Altschul and McGovern do not offer further clarification of the manner in which the nurse's presence will be 'sufficient', other writers have encouraged the the expression of a general, supportive role. Rowe (1983). a psychologist and psychotherapist, suggested that

to help a depressed person the nurse must have "a sense of humour to keep things in perspective"(p.63) believing also that:

> ...just being there is tremendously important, to show that you really do care and value the person... just 'being there' might simply mean sitting silently if he is too despairing to speak (Rowe, 1985, p.63).

Medical Concerns. Aside from this interest in the nurse's interaction with the patient, emphasis is given generally to physical care: monitoring weight, fluid intake and bowel action and offering small meals to the anorectic patient. The role prescribed by Longhorn (1984) is supportive in a very general sense. The nurse is advised to: observe the patient closely, especially where suicide is likely; be alert to changes in behaviour; express care and understanding; introduce the patient to ward activities; give a great deal of encouragement in relation to diet and personal hygeine; and be aware of the side-effects of drugs. All the texts cited so far emphasise the broad-spectrum of care, with some authors paying more attention than others to the details and importance of nurse-patient interaction.

Descriptions of the 'condition' of severe depression are commonly found in the literature, again emphasising the view of the patient from a clinical-somatic perspective. Descriptions of depressive types tend to favour the distinction between 'endogenous' and 'reactive' forms, or discussion of 'neurotic' versus 'psychotic' depression. Some authors project a positive attitude towards the physical (medical) treatment of severe depression which might be overly optimistic. For instance, Snell (1977) states that "with modern treatment endogenous depression can be

relieved in a few weeks". Only one of the authors already cited acknowledges the problems associated with such traditional diagnoses. Priest and Woolfson (1980) note that, despite the implication that endogenous depression has no obvious precipitating cause, "clinically this is rarely the case". They go on to suggest that precipitating causes may be present in psychotic depression and "there may be a significant overlay of *neurotic* symptoms" (Priest and Woolfson, 1980, p.31 : emphasis added). No specific advice, however, is offered as to the management of such symptoms or precipitating factors. Where the care and treatment of 'manic depressive psychosis', or more severe forms of depression, are discussed this is restricted in general to physical methods of treatment, especially drugs and ECT.

The Descriptive Literature

Nursing literature which describes the care of severely depressed patients in Britain appears neglibile, given the scale of the population embraced by the term. A selective review of papers published in nursing journals in Great Britain between 1976-85 is presented here. The outstanding features of this literature are: the strong representation of *student* authors and the absence of any research study of this population, or of any analysis of the medical/psychological literature. The number of articles published also appears to be small given the size of the 'depressive' sub-population within psychiatry.

The nurse learner's viewpoint. The majority of the student case studies describe the clinical features of the disorder from a medical perspective, reporting the conditions of drug therapy or in some cases

ECT or other physical methods (Round, 1982). Reference is made in these reports to socialisation, support and nurse-patient relationships, but little detail is offerred by way of illustration and no theoretical rationale. In a few of the student studies, 'psychosocial' approaches are mentioned: the use of an individualised token economy programme (Gough, 1981); or positive reinforcement and social skills training (Willey, 1984). These reports provide limited information and no formal rationale. In one study (Macdonald, 1982) counselling was cited as the key nursing intervention, but was supported by description of the role of drugs and a general 'resocialisation' programme.

Reports by Trained Nurses. A similar picture is reflected in the published reports by trained nurses. Most describe case-studies reflecting a medical model of care and treatment. The clinical features of the disorder are discussed, accompanied by descriptions of drug therapy (Gartside, 1980), side-effects of drugs and required blood analysis (Hussey, 1979), aspects of diet, physical state, preperation and management during ECT (Lindsay, 1983). With one exception (Fowler, 1981), all described routine hospital care, emphasising basic support or 'holding strategies': that is, methods of preventing problems escalating. In this context, Frost (1976) described how nurses developed a 'dressing up game' to prevent a hypomanic patient running around the ward naked. Description of psychological or psychosocial models of care are limited. Fowler (1981) used social reinforcement to reduce the dependency of a patient upon visits by a community psychiatric nurse. Dunn *and Rosen* (1982) described the use of a family therapy and problem solving approach and Dudley and Stewardson (1984)

described the use of positive and negative reinforcement in the care of a severely depressed patient. Bryant (1983) discussed the role of counselling, but emphasised its use in' reactive' depression only. The influence of cognitive therapy has been discussed (Barker *et al., 1985*; Biley, 1985), but without any detail of the evaluation of its efficacy in nursing settings. Only one of the reports reviewed made special mention of the evaluation of the patient's progress, where a rating of manic and depressed behaviour across time is described (Fowler, 1981). Only one report described a formal format for the assessment and planning of overall care for the depressed patient (Hume *et al.*, 1984).

The influence of the interpersonal school of psychotherapy was evident also in some of these reports. Hussey (1979) suggested that:

> ...because of her basic personality, it is extremely difficult to get her [the patient] to express hostile feelings...during these times the nurses try to convey to her that they are genuinely interested in her feeling well again and that she is a worthwhile person and that they honestly like her and do not look upon her as a nuisance or outcast (Hussey, 1979, p.195).

It may be fitting to conclude this review of the descriptive literature by noting briefly Gordon's (1986) study conducted in 1983. This appears to be the only published report of a nursing research study involving depressed people. This study showed that depressed women, who attended group therapy sessions under the leadership of a nurse, showed a significant decrease in depression and a significant increase in self-esteem compared with controls who received no intervention. It should be noted, however, that the subjects' scores on the Beck Depression Inventory were between 14-22 (borderline to the lower end of the moderate range of depression). This led Altschul to comment that

although the study was an example of "a well controlled study of nursing effectiveness" the subjects were "not-yet patients" (Altschul, 1986, p.xi).

The insider's viewpoint. A few descriptions of nursing care by patients have also appeared over the past decade in nursing journals. Morris (1979), a midwife who made a number of suicide attempts and was treated with ECT, described her fear of psychiatric treatment, whilst Thompson (1980) argued strongly against the use of confrontational group psychotherapy, and the abuse of power expressed by inexperienced group leaders. The other reports either emphasised the importance of self-help, and friends in the recovery process (Burns, 1978) or suggested that the treatment process, and many nurses themselves, can be heartless (Anon.,1981). One writer appealed on behalf of a patient's pressure group for a less restrictive view of treatment (Cooper, 1978). Although hardly a cohesive viewpoint, these few reports highlight some of the reservations which patients express on recovery from depressive disorder. In fairness it should be noted that other sufferers have expressed a more positive view of the contribution of nurses:

> In spite of my general lack of interest or responsiveness at the time, I could not help admiring the way in which the nurses succeeded in getting me to sit in the garden, to go out on accompanied walks, to play an occasional game of Scrabble, even to help one or two of the other patients (Altschul, 1985; pp169-70)

Altschul's observations of her 'carers' emphasised the value of some of the non-verbal supportive strategies recommended by authors cited above:

> I felt safe in a place where the nurses knew what I was doing, where people seemed to care about my safety, and where someone could always be found for a quiet chat or just sitting beside (Altschul, 1985, p170).

Influential North American Literature

This brief review of the nursing literature suggests that many British nurses continue to support a broadly biophysical model of severe affective disorder, where medical treatment is seen as of primary importance, and psychosocial intervention is supportive rather than of direct therapeutic significance (*cf.* Sugden *et al.*, 1986). There has been general acceptance that the North American psychiatric nursing literature reflects care practices which differ considerably from the British experience (Sugden, 1985). This extends to the actual professional definition of the nurse. For instance, the North American psychiatric nurse has been defined as:

> ...a professional whose *initial* educational background is through an associate degree, baccalureate degree or diploma program (Taylor, 1986: emphasis added).

By contrast, only a small proportion of British nurses have, as yet, achieved degree status. In view of such a fundamental contrast, the North American literature will not be reviewed here in any depth. Instead, the ideas of certain North American writers which have found favour with some British nurses, will be discussed briefly.

Conceptual models

North American nursing has been concerned increasingly with the development of specific models of nursing care. These tend to emphasise the presentation of the patient, rather than any hypothetical disease or illness process. Topalis and Aguilera (1978) reflect this trend by suggesting that nursing interventions "should be based upon evident problems *and* the assets of the patient" (emphasis added). This quasi-

holistic orientation contrasts sharply with the 'problem-oriented' model common in the United Kingdom, which concentrates upon amelioration of the patient's deficits, typical of the medical model. Much of the North American literature is also concerned with defining the characteristics of the relationship with the patient. Payne and Clunn (1977) emphasised the expression of certain 'therapeutic attitudes': the expression of honesty, interest, support, non-rejection, empathy and acceptance. Emphasis of this sort, upon formal strategies of 'relationship-building', is a fairly recent phenomenom in psychiatric nursing in the United Kingdom (Reynolds, 1985).

The psychotherapeutic tradition. North American psychiatry embraced the psychonalytic movement more readily than did its British counterpart. It is not surprising, therefore, that the influence of the analytic (and post-analytic) tradition is evident in much of the North American nursing literature. Although some nurses, such as Peplau (1952), have supported the interpersonal school for decades, this influence has been most evident within the past decade. As noted already, Peplau attributes much importance to Sullivan's contribution to psychiatric practice. In a more general sense, the influence of the 'culturalist' model, which developed Sullivan's concepts (Bonime, 1960), and described depression as a *practice* rather than a periodic illness, appears to be influential in the writings of other nurses such as Topalis and Aguilera (1978). Those authors suggest that the goal of interpersonal relationships with severely depressed patients is:

> ...to reassure the patient as to his worth as a person by making the acceptance of hostility easier for him(p.184).

In an even more general sense Stuart and Sundeen (1979) emphasised the need for a positive relationship between nurse and depressed patient: "depressed patients have a genuine need for *repeated* reassurance" (p.207: emphasis added).

This psychotherapeutic orientation is illustrated more specifically, and in relation to affective psychosis, by Irving (1983) who asserted that:

> ...the person who develops bi-polar disorder experiences early in life repeated failure to measure up to the expectations, first that his parents have of him and then that he has of himself. As a result he experiences hostility and aggressive feelings which he turns inwards and punishes himself for feeling as he does...and punishes as well the incorporated world and the people in it (Irving, 1983,p.203).

The patient's handling of hostility which results from his insecurity is, in Irving's view, the core problem in bi-polar disorder. The patient's method of dealing with hostility is self-punishment, in the form of feelings of despair, unworthiness, guilt and sinfulness. Irving suggests that nursing intervention should involve helping the patient channel hostility outwards: "provoking the patient's anger towards her (the nurse) or drawing his fire so to speak"(p. 219). Irving notes that the patient may request some kind of work, rather than recreation, because of his "need to atone for his sins, pay for his misdeeds, earn his way"(p.220).

Although it might be incorrect to say that the orientation of the culturalist/interpersonal school is under-represented in British psychiatric nursing, it is clear from the preceding review that its influence has, at least in the nursing literature, been minimal to

date. In terms of the practice of psychotherapy, British psychiatry, and as a result British nursing, has had a stronger association with the dynamic tradition of the neo-Freudian movement. Such traditional 'psychoanalytic' interpretation of major depression also is represented in the North American literature. Brown and Fowler (1971) viewed the depressed person as an ambivalent individual. This ambivalence was "founded upon frustrating basic nursing experiences in early infancy"(p218). They saw the patient's feelings of worthlessness as a function of loss of a love object, real or imaginary, which once incorporated leads to feelings of guilt. Finally the patient's hostility, which stems from this loss, "is directed inwards, and he begins to hate himself"(p.218). This view derives from Freud's short essay *Mourning and Melancholia, published in 1917* (Freud, 1957), in which he introduced the concept of 'object relations' and popularised the interpretation of depression as a function of loss and internalised anger. Taylor (1986) provides more recent support for this model of depressive disorder, arguing that:

> ...mood disturbances have their origins in the frustrations that occur in the late oral phase of personality development (p.327).

In her view, the nurse should provide tasks which relieve feelings of guilt:

> ...menial tasks, scrubbing floors, scouring toilets, washing dirty socks etc (which may provide) release from guilt and a means of atonement for real or imaginary sins.

She notes that this approach " has proven to be of great value to selected individuals"(p.303). Support for these guilt-atonement tactics is found also in Saxton and Haring (1979) who recommend such menial tasks. Taylor's assertion regarding the psychological development of

bipolar disorder is tempered, however, by her earlier acknowledgement that:

> ...alterations in a person's neurochemistry (the catecholamine hypothesis) may be a contributing feature in the development of manic depressive psychosis (Taylor, 1986, p.325).

Problems of living

A trend is emerging in the North American literature for more detailed descriptions of nurse-patient interactions, and an emphasis upon a 'problems of living' approach to psychiatric disorder. Travelbee's work heralded the beginnings of 'nursing diagnosis', where problems of living, rather than 'psychiatric disorder', became the subject of the nurse's *assessment:*

> The individual whose habitual behavioural response is dejection is usually diagnosed as having a *depressive reaction.* Again, the label is not important in terms of nursing intervention. It *is* important that the nurse assess the individual's ability to relate with others and then design and test approaches to assist him to break the bond of dejection (Travelbee, 1971, p.189).

Travelbee also serves as a fine example of a writer who emphasises the complexity of interpersonal relationships: they are not *common sense.*

> It is suggested that, when a depressed person begins to show signs of improvement the nurse *not* comment on the apparent improvement. Such comments may have a paradoxical effect; i.e. they may cause some ill persons to revert to their previous level of despondency (p.192).

Whereas British nurses are beginning to grapple now with conceptual problems of psychiatric nursing, especially those involving the potential conflict between 'medical' and 'psychosocial' models of care, North American nurses have a much longer history in this respect. The

interpersonal model of nursing the depressed patient has a long pedigree in the United States, represented in part by the writings of Peplau (1952) and also Schartz and Shockley who presented a vigorous rejection of the medical model of manic depressive disorder more than thirty years ago:

> There is an idea among some nursing personnel that certain patients go through cyclical periods and that each phase of the cycle has to run its course before the patient will change his behaviour. This conception might be held about a withdrawn patient who has been diagnosed manic depressive, depressed; ...with such a conception the nurse contributes to the continuation of the patient's withdrawal... Our view is that even if there is such a cyclical phase in the patient's illness the nurse can influence it in important ways by what she does with the patient (Schwartz & Shockley, 1956, pp 98-99).

Eclectic processes. Such interest in the nurse's *interaction* with the patient stems from the interpersonal model of psychotherapy, where the behaviour of the patient is seen as a function, at least in part, of his relationship with others in his environment. Nurses' interest in clarifying the details of their interaction with patients is also influenced by their interest in articulating a 'process of nursing', where the rationale for specific interactions and their eventual outcome are clarified. Although 'behaviour therapy nursing' has not been represented in the North American literature in the same way as it has in Britain, psychiatric nurses have been influenced by behavioural principles and techniques, some of which are inherent in the rational, objective structure of the nursing process. It is apparent also that some similarities exist between the 'interpersonal' model of depression and a 'behavioural' formulation of the disorder. Both acknowledge the role of learning in the development of present-day strategies for

dealing with problems of living, which are seen as being maintained by interactions with significant others in the patient's environment. Some nurses have begun to combine behavioural and interpersonal models of care. For instance, Knowles acknowledged the importance of the interpersonal model of depression, but described approaches to its amelioration which are primarily behavioural or cognitive-behavioural in orientation, emphasising activity scheduling (Knowles, 1981 a), graded task assignments (Knowles, 1981b), self-reinforcement (Knowles, 1981 c), and challenging negative thoughts (Knowles, 1981 d). Within the past decade, most North American nursing interest in psychotherapeutic treatment of depressed patients has focussed upon the use of either group therapy and cognitive-therapy. Van Servellen and Dull (1981) described the function of a group therapy model which specifically focussed upon the experience of women, whilst Helm (1984) and Manderino & Bzdek (1986) have indicated the potential of cognitive approaches. The North American literature, however, has paid little attention to the phenomenom of 'depression' *per se*. From Peplau's viewpoint this is because nurses are more concerned with presenting problems, such as hopelessness, self-control and anxiety, which cut accross various diagnostic categories, rather than with diagnostic 'entities' such as *depressive disorder* (Peplau, 1985). This view is shared also by the American Nurses Association which stated that:

> ...nursing is the diagnosis and treatment of *human responses* to actual or potential health problems (ANA, 1980 : emphasis added).

Evaluation of the psychiatric nursing literature

The brief review of the literature presented suggests a gradual lessening of the divide between North American and British nursing practice in relation to care of patient with affective disorder. Although some North American texts still emphasise psychoanalytic interpretation and intervention, stronger support is evident for an interpersonal model, which in turn may be being overtaken by more eclectic approaches which appear more empirically defined, such as the cognitive therapy model. The British nursing literature has maintained a strong medical-expressive orientation up to the present day. However, interest in the interpersonal nature of care has generated support for an interpersonal model, which as yet is not articulated clearly. The assertion that nursing should be governed by an interpersonal model appears to stem from writers like Travelbee who observed that:

> ...nursing *is* an interpersonal process because it is always concerned with people either directly or indirectly (1971).

In Britain, Altschul has been instrumental in generating the enquiry into the nurse's interpersonal role. In her study of nurse-patient interaction, she noted that the diagnosis of the patient seemed to influence the amount of interaction time patients received, neurotic (sic) patients receiving much less time than others. This finding was supported later by McIlwaine (1981). Altschul (1972) found it impossible to identify any specific treatment ideologies amongst the nurses she studied, which led her to question whether or not they had "any identifiable perspective to guide them in their dealings with problematic situations"(pp191-2).

The interpersonal base of psychiatric nursing

That interpersonal situation, and the stresses inherent within it, was acknowledged in Menzies' seminal study in which she noted that the nursing service bore the full and concentrated impact of stresses arising from patient care (Menzies, 1961). Such pressures appear to be linked inextricably to the nurse's role as the medium of institutional treatment. Wilson-Barnett and Trimble (1984) observed that in this role nurses acted as a buffer between the institution and the individual patient, exerting a powerful influence, for good or ill, on the outcome of treatment. Nurses demonstrate this role in fairly 'naked' terms. Any technical actions undertaken are sub-contracted medical procedures. The only procedures which nurses 'own' are a function of their own selves, such as helping a patient discuss a problem, or helping a patient to eat. As noted earlier, many North American writers have articulated a philosophy of interpersonal 'therapeutic' relationships for many years (Peplau,1952; and Schwartz and Shockley,1956). Although, as noted earlier. such ideas about interpersonal relations can be traced to various schools of psychotherapy , especially Sullivan , anthropologists (Mead, 1934) as well as psychologists (Mahoney, 1974) have documented their appreciation of the fundamental principle that one person's behaviour is affected by, and in return has an effect upon, the behaviour of others. The value of North American nursing authors such as Peplau, has been in translating such concepts for a nursing audience.

The constituents of care. Three facets of psychiatric nursing care of the patient with affective disorder emerge from this review. The most

fundamental role involves the organisation of a supportive social environment, where recreation, distraction and social stimulation are offered. The second level involves more direct care and treatment, with nurses 'expressing' discrete medical prescriptions, such as giving drugs and monitoring side-effects, and assisting in the delivery of ECT. At this level, the nurse's concern for the patient's physical health, through supervision of personal hygeine, diet and activity and biological rhythms, also is expressed. The third level deals specifically with the nurse's attempts to use her 'self' to help the patient.

Most contemporary writers assert that this use of 'self' is the most important function of nursing. Butterworth has commented recently that an unwelcome ideological shift back to a medical/general nursing frame of reference is likely to result from proposal to make radical changes in nurse training. In order to restate the purpose of psychiatric nursing Butterworth argued that psychiatric nurses must:

> ...declare an expertise in interpersonal skills, the therapeutic use of self and the difference that psychiatric nursing has in its final (sic) detail and consequently ideology (Butterworth, 1987, p.6).

With this restatement of purpose in mind, it is appropriate to consider the nature of the nurse-patient relationship described in the literature review.

The therapeutic use of self

Although British nurses have begun a move towards an interpersonal approach, it is unclear whether this represents an *ideology, 'science*

of ideas' or theoretical rationale, in Altschul's sense of the word. Although the literature reflects an interest in nurse-patient interaction, interaction and relationship are not synonomous. As Laing (1965) observed, viewing the other as a *person* implies a different perspective on the part of the observer to viewing the other as a biological or mechanical entity. Those who would like to see nursing established more securely on the basis of interpersonal relationships seem to suggest that caring for depressed persons should involve relating to the other as a person, helping to identify and work upon the problems in the patient's life. However, some traditional treatment models have abstracted a disease or disorder from out of the person. This identified phenomenom (the condition) then becomes the focus for the doctor's and nurses attention. As this review has noted, many nursing writers continue to talk about the disease, or disorder, as if it existed seperately from the person who is the patient. This reductionist orientation appears to be in direct conflict with interpersonal model of nursing, as projected by writers like Schwartz and Shockley (1956)

The expression of sympathy. Although British writers like Beccle (1962) were describing quite passive 'policing' roles for nurses at the beginning of the 1960's, their North American counterparts had already stated their assumptions about the potential influence which nurses might have upon even seriously depressed patients (Schwartz and Shockley, 1956). When British nurses described nurse-patient, interaction three strategies are recounted. In the first, the expression of a sympathetic attitude is recommended (Bray and Bird,

1964; Burr and Andrews, 1981; and Darcy, 1984). Although sympathy implies the sharing of the patient's distress, it is not defined clearly and certainly can be distinguished from empathy (Altschul and McGovern, 1985; Reynolds, 1986) which implies a different form of emotional involvement.

The expression of reassurance. The tactic of reassurance represents another 'use of self' intervention which is recommended often (Darcy, 1984; Trick and Obcarskas, 1982), but which remains ill-defined in most cases. Although it can be assumed that such 'positive' approaches to the patient's distress will be helpful, some authorities warn against inappropriate usage. Arieti (1980) has suggested that:

> Exaggerated reassurances may be detrimental rather than beneficial in allowing the patient to believe that the therapist (sic) shares his own estimation of his helplessness and terribly impaired state (p.295)

He also cites Bonime's (1962) observation that false reassurance at almost any time is harmful, and probably never more harmful than when a patient is depressed. In Bonime's view, this encouraged the patient to believe in his own powerlessness. False reassurance serves only to obscure the patient's genuine resources instead of mobilizing them. From this perspective, Trick and Obcarskas' assertion that the nurse dare not refuse the patient's requests for reassurance, may require further clarification. Although many nursing writers assume that nurses *should* try to ease the patient's distress in this fashion, Arieti is quite emphatic that from a psychotherapist's viewpoint:

> from the very beginning the patient must understand that ...amelioration is his therapeutic task and not an obligation of the therapist (Arieti, 1980, p.295).

The expression of general support and acceptance. The final strategy described involves forms of non-verbal support. This is illustrated by the assertion that "just being there" (Priest and Woolfson, 1980) or "merely listening" to the patient talk about his despair and hopelessness, can be therapeutic (Darcy, 1984). Although not citing affective disorder in particular, some researchers have demonstrated that the opposite is the case (Gelfand, Gelfand and Dobson, 1967) where 'passive support' reinforces the helplessness of the patient. Although support for such a therapeutic tactic might derive from 'conventional wisdom', research evidence to support the 'therapeutic use of self' in this arbitrary fashion appears lacking. Researchers like Beck *et al.*(1980) have suggested that time spent engaged in long silences with a depressed patient merely affords the person time for rumination: time to form the opinion that the 'silent other' supports the hopelesness of his state. Although representing a quite different psychotherapeutic culture, Arieti agrees with Beck about the need to avoid the adoption of a "silent analytic posture":

> ...to remain silent and let the patient recount his miserable state is to further the transference distortion of an omnipotent other (Arieti, 1980,p.295)

Instead, he argues that there is a need to be "active and forthright," trying to initiate discussion of other topics to prevent the reiteration of symptoms, at least in the early stages of the interaction, where the relationship is being formed with the patient. Although it is not clear how much of this advice to practitioners of psychotherapy is relevant to nurses, as a general principle these two views about the danger of silent postures suggest the need for the further examination of this concept in nursing practice.

The North American literature reviewed here appears more specific, by comparison, in its description and definition of 'therapeutic attitudes' (Payne and Clunn, 1977). That literature also reflects more of the ideological conviction which is less obvious in British nursing practice. Some nurses maintain the traditional 'Freudian' interpretation of severe depression in terms of critical infantile personality development (Brown and Fowler, 1971; Taylor, 1986), with some authors emphasising Freud's concept of the introjection of anger (Irving, 1983). Some authorities would suggest, however, that Freud's bold and imaginative formulation of severe depression has not stood the test of time, having proved "increasingly difficult to corroborate by clinical evidence"(Arieti, 1980, p.23). Although some British nurses share an interest in traditional psychodynamic interpretations of depression, there are indications, however, that the American 'culturalist' model, espoused by Topalis and Aguilera (1978), is becoming more influential. This acknowledges the concept of affective disorder as a 'practice' rather than an 'illness' and also emphasises the complexity of interpersonal relationships (Travelbee, 1971). Some North American nurses have integrated the interpersonal model with more empirically defined interventions, like cognitive therapy (Knowles, 1981d; Manderino and Bzdek, 1986) which embraces some of the principles and practices of behaviour therapy. Alternatively, Shanley (1984) has projected a rather negative view of British psychiatric nurses training in behaviour modification (sic) techniques and principles, in which he perceives a "danger....in the nurse seeing herself merely as a technician "(p.200). Despite that reservation, most British nurses who practice behavioural psychotherapy acknowledge the crucial role of

interpersonal relationships and mirror many of the attitudes and practices of their North American nurse psychotherapist colleagues (*cf* Barker, 1982; Barker and Fraser, 1985).

Conclusion

This review shows that three main care functions, of the patient with affective disorder, have commonly been described in the British nursing literature. These represent the organisation of a living environment which offers general support, the expression of medical treatment and the use of self as a therapeutic tool. Theoretical rationales for the adoption of these different strategies of care are assumed but rarely articulated. Although some authors have acknowledged the distinct status of the patient suffering from manic depressive psychosis, no specific nursing interventions for this group has been described. It is assumed that if these three care functions are appropriate for patients with affective disorder in general, they will also be seen as appropriate for the care of the patient suffering from manic depressive psychosis.

CHAPTER 5

CRITICAL APPRAISAL OF THE SCOTTISH RMN TRAINING PROGRAMME: SUB-STUDIES 1 and 2

The preceding review of the literature reflects the views of nurse researchers, educationalists and clinicians on what nursing care of the depressed patient *should* and *does* involve. Although there is no evidence to support the following view, it could be hypothesised that published reports do not reflect the majority view of the content, rationale and function of care. In this chapter, an attempt will be made to clarify further the role of the nurse in the care of patients suffering from any form of affective disorder by examining what is expected of nurses undertaking the training programme leading to the examination for the mental part of the register in Scotland. This appraisal takes the form of two sub-studies. In sub-study one, the content of the General Nursing Council for Scotland's scheme of training for the Mental part of the register was examined, with specific reference to aspects of caring for patients suffering from affective disorder in general. The focus of this study was the sample curriculum prepared by the General Nursing Council for Scotland in 1978. In the second sub-study, questions from the written examination, which specified aspects of caring for patients with affective disorder, were studied.

Sub-Study 1: The R.M.N. Curriculum

An appreciation of the role of the psychiatric nurse can be gained from observation of the educational curriculum for nurses who are training for the mental part of the register. The General Nursing Council (G.N.C.) for Scotland, provided a general framework for training in the form of sample curricula, which were interpreted by Colleges of Nursing and Midwifery at a local level. All training programmes, planned by individual colleges, were submitted for approval to the General Nursing Council for Scotland. With the demise of the General Nursing Council for Scotland, responsibility for all nurse training in Colleges of Nursing and Midwifery, was transferred to the National Board for Nursing and Midwifery for Scotland. The present scheme of training for the Mental part of the register, derives from a sample curriculum which was prepared in December 1978 by the G.N.C. for Scotland. This curriculum was expected to come into force approximately three years later, in 1982. The curriculum contained in the *Schemes of Training for the Register of Nurses* (General Nursing Council for Scotland, 1978) outlined the rudimentary content of eight required modules of training leading to the examination for the register. The first four modules represented part of a common programme shared with nurses training for the general part of the register. The second four modules were designed specifically for the mental part of the register.

Acute and non-acute mental disorder

The sample curriculum for the Mental register makes no specific mention of the *care* of patients suffering from manic-depressive psychosis. Theoretical teaching is, however, recommended on 'affective disorders'

in module six (non-acute mental illness) and seven (acute mental illness), of the sample curriculum. It is not made clear whether this relates to the theory of medical practice, such as diagnosis, epidemiology and treatment, or the theory of nursing related to specific populations. In the *Schemes of Training* document, an acknowledgement is made to the need to draw a distinction "in terms of experience of non-acute conditions and of acute conditions"(p.46: para 107). In an appendix to the *Schemes of Training* document (Appendix 4a: Topics 25 & 27), affective disorder is cited within both the acute and non-acute psychiatric conditions, but any distinction, in terms of the nursing care required, is not amplified. However, little specific mention is made in the *Schemes of Training* document to the nurse's role in caring for patients with any specific mental disorder.

It has been noted already that there is a long tradition of interest in the nurse's actual or potential psychotherapeutic role (Cormack, 1983). Specific mention to such a role is negligible in the Schemes of Training document. Where 'psychotherapy' (or indeed any treatment) is mentioned, caution is expressed:

> The straightforward caring role of the nurse should not be lost sight of, however, in speaking of the extensions of that role into specific treatments and psychotherapy (General Nursing Council for Scotland, 1978, p.46: para 109).

This seems to suggest that 'caring', and helping patients through some form of psychotherapy, are different, if not conflicting, activities. In this respect, the General Nursing Council for Scotland appears to reflect a quite different view from that of the American Nurses Association referred to earlier (ANA, 1980).

As has already been noted, there is a long tradition of debate concerning the meaning of the term 'mental illness' in psychiatry. The *Schemes of Training* document reflects some of this uncertainty when it appears to suggest that some disorders are treated (only) in hospital *or* the community; and that there is some distinction between mental *disorder* and mental *illness*. Para 110 of the document states that students should be exposed to "full coverage...of disorders which would normally be treated in the mental hospital" and also:

> ...should be taught the symptoms of the main disorders which would normally be treated outside the mental hospital (Para. 110).

The importance of teaching students about the "symptoms" of disorders, rather than 'care' of people suffering from specific disorders, is not clarified. A question could also be raised about the kind of disorders which are treated only in the community, or only in the hospital. It could be argued that the severity of the patient's illness, rather than the nature of the illness itself, determines whether or not (s)he will require hospital treatment. In the same paragraph the document adds that:

> ...special emphasis should be placed upon the disorders... *which give rise to mental illness* (emphasis added).

This implies that the disorders and the illness are separate yet interdependent entities (or concepts). The distinction is rendered tautological by reference to the Mental Health (Scotland) Act which stated that 'mental disorder' means "mental illness or mental deficiency however caused or manifested" (Mental Health Act, 1960).

The nurse's interpersonal role

Although the *Schemes of Training* document appears to exercise caution in identifying a specific psychotherapeutic role for psychiatric nurses, it does not ignore reference to engagement in formal and informal mechanisms of psychotherapy. The document suggests, for example, that teaching should stress "the *nurse's role* of giving support to the patient through *friendly interest and concern*" (para 108: italics added). In Appendix 4A of the document, "list of topics 25" cites only interest, concern and respect, under nurse-patient relationships. These requirements of the nurse appear limited by comparsison to Payne and Clunn's (1977) therapeutic attitudes quoted earlier, which emphasised honesty, support, non-rejection, empathy and acceptance. The document does, however, make special reference to teaching in relation to the "role of the nurse in individual and group methods of psychotherapy" and the "nursing care of patients receiving special treatments (sic) - desensitisation" (General Nursing Council for Scotland, 1978, p. 70:list of topics 27).

A clearer appreciation of the Council's view of the role of the psychiatric nurse is gained from Appendix 6 to the *Schemes of Training* document. This refers to "tasks for which the registered (mental) nurse accepts responsibility." Under "management and communication", ten general administrative duties are cited, including, admission, transfer and discharge *documentation*; security of possessions, keys etc; *custody* of drugs etc; ward stock control; reporting defects in equipment; dealing with absences; preparing on/off duty schedules. The same section cites seven tasks related to clinical care, namely: using

restraint; advising patients and relatives; co-operating in therapies; participating in group therapy, behaviour modification therapy (sic); promoting good physical and social habits; supervising and participating in recreational activities; and "preparing, monitoring and evaluating nursing care plans." A second section identifies thirty tasks under "Nursing Care". Only four of these tasks relate specifically to the care of the mentally ill, namely: i) assisting patients - listening, reassuring, suggesting, persuading; ii) recognising and dealing with - depression, aggression, anxiety, confusion, elation, delusion, hallucination; iii) observing and recording ; and iv) informal(sic) assessment of mental state and social behaviour. The distinction between "observation and recording" and "informal assessment" is not clarified. The remaining tasks deal with forms of clinical-somatic nursing care, such as: removal of sutures; treatment of the throat by painting and gargling; after-care of patients following ileostomy; barrier nursing.

It would be inappropriate to judge the General Nursing Council for Scotland's view of the role of the Mental nurse on the basis only of this outline syllabus. A number of points are, however, worthy of comment. First, the training is geared towards *patients* in hospital, rather than towards *people* suffering from mental disorder wherever they might be living. This may be a reflection of attitudes prevalent at the time of the drafting of the document. The Council's document states, however, that the nurse views the patient:

> ... as a person who, at one level or another, needs help in maintaining *basic* human functions (and that) the patient may be in hospital or outside of it (page 30; para 6 : italics added).

However, the role described under 'tasks' (see above) is related almost exclusively to hospital work. Secondly, reference to *basic* human functions is important, since it is not clear, from the review of the *Schemes of Training* document above, which of the needs of the patient are basic or which are *advanced.*

The reference to meeting basic needs may explain why the document recommends that nurses should only *assist* medical and other staff (such as clinical psychologists) in the performance of assessment or special treatments (p.111).

The document gives little emphasis to the importance of nursing care plans, or the assessment of the patient (person) upon which these are based. This is worthy of note since the Scottish National Nursing and Midwifery Consultative Committee (1976) published a seminal series of papers on the process of nursing before work began on the *Schemes for Training* document. The outline syllabus gives no indication that different kinds of care plans might be needed by people suffering from different disorders, or who are at different stages of their illness. Indeed, the document suggests that

> The nursing process is the application of ordinary intelligent behaviour to the care of the patient (p.31:para 10).

If the nurse is to be "concerned with the patient as a whole person, body and mind"' (General Nursing Council for Scotland, 1978,p.30: para 7), then the assessment of the person would need to take account of at least the following: the patient's view of herself (especially in the case of the severely depressed person); interaction with peers and

family; her view of these interactions; opportunities for self-harm, deliberate or otherwise; motivation towards and engagement in self-care; ability to express emotion; and identification of the person's needs, as opposed to those defined by staff (see Barker, 1985). The critical nature of these needs, especially in the case of the suicidal patient suggests that the design of appropriate care might involve more than "ordinary, intelligent behaviour".

Sub-Study 2: The Written Examination

This brief appraisal of the recommended outline for Registered Mental Nurse training suggests that although an appreciation is gained of the General Nursing Council for Scotland's expectations of the nurse caring for the patient with affective disorder, implicit in the sample curriculum, an accurate assessment of their expectations is not possible. To gain a more direct appreciation of the governing body's orientation towards care of patients with affective disorder, questions concerning care of such patients were abstracted from the final examination papers for the register between 1976-85 (See Appendix I). An analysis of these questions undertaken by the author is shown in Figure 5:1. The first five questions are drawn from the present training programme, which is based upon the recommendations in the *Schemes for Training* document. The remaining questions are drawn from the earlier scheme of training (pre-1982) approved by the General Nursing Council for Scotland.

The content of the questions

In Figure 5;1 the presentation of the patient is noted in the first two columns and the class of information requested, in the subsequent columns.

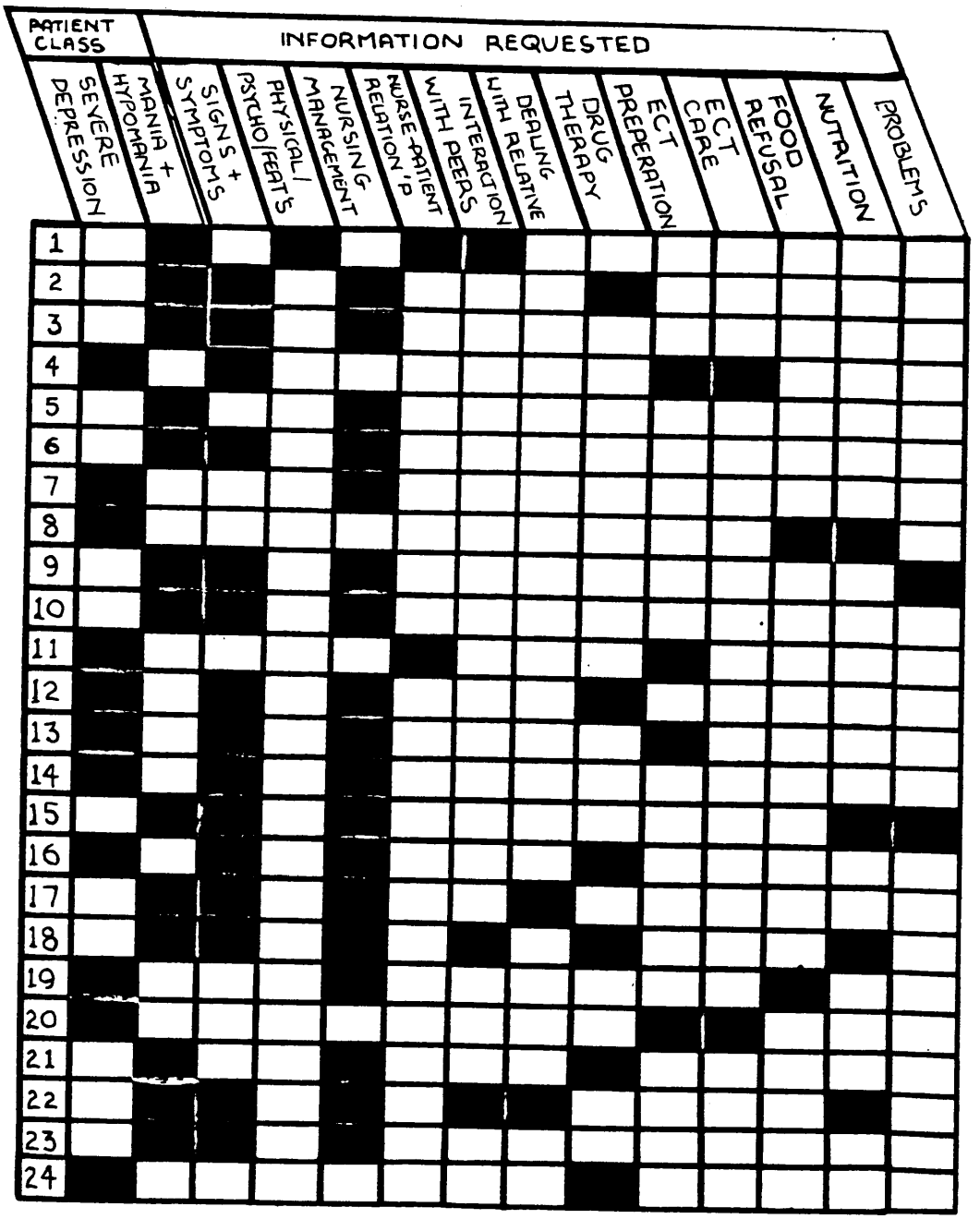

Figure 5.1 Classification of the Content of the RMN Course Examination Questions

The figure shows that, despite their relative rarity, mania and hypomania are cited more frequently (13 times) than severe depression (11 times). Weissman & Myers (1978) suggest that the incidence of mania is between 0.6 and 1.0 %; and of depression between 3.2% for men and 5.2% for women. Where the question asks the nurse to describe the presentation of the patient, this appears to be framed predominantly within a clinical-somatic (medical) model, including: requests for signs and *symptoms*; *clinical* features; or *clinical* presentation. In some cases the nurse is asked to describe the care of the 'condition' rather than *patient*.

Most questions (75%) ask the examinee to describe the "nursing care" of the patient (or his "condition"). Where additional information is requested, this tends to emphasise the role of drugs, ECT or physical factors - nutrition, hydration, physical deterioration. Requests to discuss social or interpersonal aspects of nursing care are rare. Despite the controversy which has surrounded the use of ECT over the past decade in particular, where ECT is cited the examinee is never invited to comment upon the appropriateness or otherwise of the treatment. This might suggest that ECT is assumed, by the examiner, to be appropriate in all cases. The nurse is *never* asked to discuss her advocacy role in respect of consent to ECT in particular, or drug therapy in general. Despite the assumptions noted earlier about the interpersonal role of the nurse, only two questions emphasised nurse-patient relationships.

Assessment Of The Examination Questions By A Panel of Judges

To clarify whether or not the examination questions posed by the General Nursing Council for Scotland and latterly, the National Board for Nursing and Midwifery for Scotland, reflected any consistent 'ideological' orientation, the full selection of questions was submitted to examination by an independent panel of judges. This sub-study hypothesised that no consistent model of care and/or treatment would be reflected in the examination questions.

Method

A purposive sample (Kerlinger, 1986) of 17 senior nurse clinicans and teaching staff members was drawn from four Colleges of Nursing and four psychiatric hospitals : two Colleges and hospitals were sited in the East of Scotland, and one hospital and one College each in the West and South of Scotland (See Table 5:1). All participants were known to the author.

Table 5:1 Composition of Panel of Judges

	Post		
	CT	T	C/N
East	3	2	3
South	2	1	2
West	1	1	2

CT : Clinical Teacher
T : Tutor
C/N : Charge Nurse

The panel was asked to assess the ideological orientation of the 24 examination questions. Each respondent was supplied with a copy of the questions and was asked to read each question part and to decide which model of mental health/disorder was reflected by the context of the question. The panel was asked to classify each question part using the

list of conceptual models shown in Table 5:2. This list of 'conceptual models' was provided by four members of the teaching staff of a College of Nursing where the author was an honorary member of staff. The full list of questions is shown in Appendix 1.

Table 5:2 List of conceptual models

A: Medical model	F: Interpersonal model
B: Behavioural model	G: Cognitive model
C: Social model	H: Existentialist model
D: Gestalt model	I: Psychoanalytic model
E: Psychodynamic model	J: Eclectic & Nursing Process

The list of 'conceptual models' selected as the framework for judging the examination questions, represented the range of theoretical models commonly used in nurse training for the explanation of psychiatric disorder, or which served as the basis for specific treatment approaches. Item J (Eclectic and/or nursing process) does not represent a model *per se*. This was included on the assumption that examination questions might ask the student to 'explain' the nursing care of a patient with a specific disorder. In responding to such a question the examinee would be free to involve any conceptual model, or elements from more than one model, in the design of the care plan.

The list of questions and instructions was mailed to each judge who completed his/her response independently, mailing the replies back to the author. No other communication between the author and panel members took place.

Results

The panel's responses' are summarised in Table 5:3. In some cases the respondents chose two or more models as optional response categories. In the Table, the responses have been simplified by accepting only the *first* response made to each part of the question. A small minority of the respondents suggested that some questions 'invited' the use of one conceptual model, but others were included as possible alternatives. The judges' responses suggested that the majority of the questions invited the use of a 'medical model' of care (86%). Recognition of a specific requirement to use an 'eclectic' or nursing process format was the second most frequently identified response, with 6.6% of the responses overall. An implicit emphasis upon a social or interpersonal model of care was adjudged evident in only four question parts and represented only 3.7% of the judges responses.

With the exception of one question (No.19) the panel were in full agreement that the first part of each question reflected a medical orientation. The panel judged the majority of the remaining question parts, as reflecting a medical model of care and treatment, with six exceptions.

In question 1:b the majority of the panel identified an interpersonal or social model as most appropriate, where the examinee was asked to

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'·In Table 5.3 the following abbreviations are used to represent the response categories. Med. = Medical; Behav. = Behavioural; Soc. = Social; Psych/D. = Psychodynamic; Interp. = Interpersonal; Cog. = Cognitive; E.N/P = Eclectic or nursing process.

*Table 5:3 Ideological Orientation of Examination Questions**

Question/ Part No.		Classification						
		Med.	*Behav.*	*Soc.*	*Psych/D.*	*Interp.*	*Cog.*	*E. N/P*
1 :	A	17						
	B			4		10		3
	C		6	2				9
2 :	A	17						
	B	15	- 1					1
	C	17						
3 :	A	17						
	B	17						
4 :	A	17						
	B	14	1					2
	C	17						
5 :	A	17						
	B	15						2
6 :	A	17						
	B	14	1					2
7 :	A	17						
	B	14						3
8 :	A	17						
	B	14			1			2
	C	17						
9 :	A	17						
	B	13				1		3
	C	17						
10:	A	17						
	B	16						1
11:	A	17						
	B	13	3					1
	C	17						
12:	A	17						
	B	16						1
13:	A	17						
	B	17						
	C	15				1		1

* Three categories (Gestalt, existentialist and psychodynamic) were not used by the respondents and were omitted from the table.

Table 5:3 (cont'd)

Question/ Part No.		Med.	Behav.	Soc.	Psych/D.	Interp.	Cog.	E.N/P
14:	A	17						
	B	16						1
15:	A	17						
	B	14				2		1
	C	15						2
16:	A	17						
	B	14						3
	C	17						
17:	A	17						
	B	13	1					3
	C			1		7		9
18:	A	17						
	B	13	1					3
19:	A	16					1	
	B	14				1	2	
	C	3				1		13
20:	A	17						
	B	17						
	C	14						3
21:	A	17						
	B	14	1					2
	C	17						
22:	A	17						
	B	17						
	C	4		5		8		
	D	1	1	6		9		
23:	A	17						
	B	17						
24:	A	17						
	B	17						
Totals		922	16	18	1	40	3	

"discuss how the nurse should respond to the problems which can occur when establishing a relationship with this patient". In the third part of this same question, the panel favoured an 'eclectic or nursing process' (n=9) approach, closely followed by use of a behavioural model (n=6). This question asked how the nurse would deal with other patients becoming annoyed by the behaviour of the patient. In 17:c, the panel suggested that the question "how should the nurse deal with problems posed by visitors to the ward?" reflected an eclectic/nursing process (n=9) or interpersonal (n=7) model. Question 19:c asked the examinee to "discuss the important principles to be learnt from this situation (a patient refusing to eat or drink)". This was judged primarily as an eclectic/nursing process model (n=13). Finally, question 22:c asked how the nurse would reassure a distressed spouse and 22:d asked the nurse to discuss the possible effects of the patient on other patients. Both these question parts were judged as predominantly interpersonal or social in orientation.

Discussion

The response of the panel of judges suggests that the examination questions of the past decade offer an *implicit* invitation to examinees to describe patients suffering from affective disorder and their care and treatment, from the perspective of a medical model of psychiatric treatment, rather than any other. Consequently, the hypothesis that no consistent model of care or treatment would be expressed in the questions was not supported. A senior lecturer in nursing studies commented that :

> ...since the medical model is the most pervasive model in psychiatry, students are most likely to use the medical model even for questions where the use of other models is equally appropriate (Shanley, 1986).

He added that students' interpretation of questions will be influenced by "cues from the stem, such as 'signs and symptoms' or 'clinical' ". In this vein it is interesting to note that apart from repeated reference to signs and symptoms and clinical features, question 3 asked the student to comment upon the management of a "condition", rather than the 'care of a *person* suffering from a specified condition'. This question, taken from a recent examination paper for the revised 1982 syllabus, is in direct conflict with the 'person-centred' approach espoused by the General Nursing Council for Scotland. Although the response of the panel of judges suggested that the eclectic and/or nursing process approach was the second most frequently 'invited' conceptual format, this approach was greatly under-represented. Despite the growth of interest in the use of the process of nursing since 1976, in nurse training (Drummond, 1987) and the nursing literature (see Cormack, 1985) this approach did not appear to play a significantly greater part in the post-1982 examination questions than in previous years. Given the interest in the psychosocial context of care noted in Chapter 4, the placings of interpersonal and social models of care and treatment in the panel's overall judgement seem almost insignificant.

A study of the contemporary curricula in Scottish Colleges of Nursing (Barker, 1986) revealed that some Colleges maintain an emphasis on teaching of "major features/aetiology and care for patients in (different) categories...psychotic versus neurotic depression"

(Henderson, 1986) reflecting the "traditional medical model"(Straiton, 1986). However, other colleges reported an emphasis upon "nurse patient relationships, therapeutic interactions etc "(MacDougall, 1986) and teaching of specific psychoanalytic (Freud, Klein and Bowlby), psychodynamic (Arieti & Lewin) and behavioural theories (Seligman, Lewinsohn, Beck). Lyttle (1986) also emphasised the teaching of Gestalt techniques, Reynolds (1986) the role of group dynamics and Drummond (1986) among others, the importance of cognitive (information-processing) theory. These conceptual models, and their accompanying therapeutic methods, were not represented to any real extent in the judges' classification of the examination questions. Gestalt, existentialist and psychoanalytic models of depression were not cited by any judge; cognitive (three judges) and psychodynamic (one judge) models faring little better.

It could be argued that students are free to answer the question from any theoretical standpoint they wish, using the model of care or treatment they believe is appropriate. However, some senior nurse tutors support Shanley's observation of the pervasive 'power' of the medical model. If a student decided to frame an answer around an atypical model of care or treatment (such as a psychodynamic interpretation of depression) this response might be considered inappropriate, even incorrect, given the strong representation of medical treatment of these conditions, by drugs and E.C.T. (Drummond, 1986) In his view, the examination requires students to take an unnecessarily "medico-nursing" orientation in order to pass the examination (Drummond, 1986).

Conclusion

All final examination for the Mental part of the register set between 1976 and 1985, were assessed by an independent panel of judges, in an attempt to classify the 'ideological orientation' of the individual questions. The judges used a list of ten conceptual models, or theoretical frameworks, which were considered relevant to the understanding of mental illness and the practice of psychiatric nursing. From the the appraisal by the panel of judges it would appear that the written examination for the Mental part of the register asks more questions about the *diagnosis* of affective disorder and about the expression of medical treatment, than about the discrete role of the nurse in caring for people suffering from such disorders. In the judges' view, the majority of the questions 'invited' answers which would use a 'medical model' of care and treatment, rather than any other. Although examinees would have been free to use any conceptual model as the basis of their description of nursing care, where such a description was asked for, some judges thought that a 'medical' model of care would be more acceptable than any other.

CHAPTER 6
CLINICAL NURSING OF THE PATIENT WITH AFFECTIVE DISORDER:
SUB-STUDIES 3 AND 4

The two representations of the nurse's role in the care of the patient suffering from affective disorder presented already, involve *interpretations* (the prescriptive and descriptive literature in Chapter 4) or *expectations* (the training programme described in Chapter 5). To gain a more direct appreciation of how nurses see their role in caring for patients with affective disorder in general, and manic depressive psychosis in particular, two sub-studies were implemented. The first was based upon a structured interview, completion of a questionnaire and rating scales. The second sub-study was based upon use of the Critical Incident Technique (CIT), described by Flanagan (1954). Both studies sought to answer the following questions:

1. How do practising nurses perceive their role when caring for patients suffering from manic depressive psychosis in particular, or affective disorder, in general?
2. What do nurses believe that they do for the patient?
3. What is the nurses' rationale for taking one, rather than any other, course of action?

In Chapter One it was noted that considerable uncertainty surrounds the diagnosis of 'manic depressive psychosis'. In Britain in particular, there exists a strong view that manic depressive psychosis is no more than a severe form of other affective disorders (Kendell, 1983b; Naylor, 1987). This thesis is concerned with the nursing care of

patients diagnosed as suffering from manic depressive psychosis, rather than any other form of affective disorder. The main experimental study reported in Part Three of the thesis was implemented in a research unit which specialised in the care of women with affective disorder in general, and manic depressive psychosis in particular. In view of the specialist status of this ward, and therefore the specialist experience of the nurses, the first sub-study (3) reported below, examined the nurses' perception of their role in caring for patients diagnosed as suffering from manic depressive psychosis *per se*. The second sub-study (4) employed a random sample of psychiatric nurses from psychiatric hospitals and psychiatric units throughout Scotland. Before commencing this sub-study it was acknowledged that because it was drawn at random, some of the sample might have had only limited experience of caring for patients with an unequivocal diagnosis of manic depressive psychosis, given the size of this population. For this reason it was decided to examine these nurses' perception of caring for patients with affective disorder in general.

Sub-Study No.3: The Role of Trained Nurses in the Experimental Ward

This study focussed attention upon the orientation to care of the patient with manic depressive psychosis, expressed by staff working on the ward in which was to be based the experimental project described in Part Three. The ward had been used for approximately 15 years as a base for research into the aetiology and medical treatment of patients with affective disorder in general and manic depressive psychosis in particular. Largely for practical reasons of architectural design, the ward

accomodated only female patients. At the time of this sub-study, the nursing team were all women.

Aims of Sub-Study Three

In the experimental study described in Part Three a comparison was made between different nursing interventions in the care of patients with manic depressive psychosis, comparing 'routine nursing care' with two alternatives. As noted in the introduction to Part One the definition of 'routine nursing care' was planned as a composite: based upon descriptions in the nursing literature, descriptions of nursing care contained in nurse training literature and reports by nurses of the content and function of their work with patients suffering from depression.

As part of this clarification of the nurse's role the study reported here aimed to describe the interactions which trained nurses on the experimental ward used in their 'routine nursing care' of women with manic depressive psychosis.

Materials and Method

The study involved three phases (see Figure 6.1). In the first phase, all staff were interviewed by the author. These interviews took the form of two group discussions, where staff were asked to identify the content of 'routine nursing care' on the ward. In the second phase, a two-page questionnaire which comprised 11 questions (see Appendix 2), based upon the responses from the group discussions, was given to trained staff members only. Finally, two rating scales, comprising 20

items each, were given to trained staff only. These scales were based upon an analysis of the responses to the questionnaire used in the phase two. The first scale asked the nurse to indicate how often she would engage in each of the twenty 'interactions with patients' defined in the scale (see Appendix 3), using a five-point scale which ranged from A (almost every day) to E (never). The second scale, which used the same five-point rating, asked the nurses to indicate how often, approximately, they would be expected to deal with the twenty clinical problems listed (see Appendix 4). The three phases were conducted over a three-month period.

Figure 6.1: The Three Phases of Sub-Study 3.

Phase	*Content*	*Outcome*	*Duration*
1	Group discussions with staff team.	Key areas of interaction.	2 weeks
2	Completion of questionnaire: trained staff only.	Nurses' perception of their role.	1 week
3	Completion of Scales 1 and 2: trained staff only.	Indication of prevalence of: 1) clinical problems and; 2) use of inter-personal actions.	1 week

Subjects

14 staff participated in the group discussions in the first phase. The 'staff team' comprised seven trained nurses (four registered mental nurses, one registered general nurse and two state enrolled nurses), four nursing assistants, two student nurses and one clinical teacher (who was responsible for supervising all nurse learners attached to the

ward) In the second and third phases, only the seven trained nurses, who were full-time members of the ward team, participated. The average length of post-qualification experience in psychiatric nursing of the trained group, was 11 years: range 2 - 23 years.

Results

Phase 1: The two discussion groups yielded nine areas of nurse-patient interaction. These were:

Establishing positive relationships with patients.
Spending time talking to patients.
Encouraging recreation.
Collecting information about the patient's condition.
Giving general information to the patient.
Giving the patient information about her treatment.
Witholding certain information from the patient.
Giving information to the patient in different ways.
Responding to the patient's questions.

These nine areas of interaction were re-written in the form of an open-ended questionnaire (see Appendix 2 for a completed example) to which were added two further open-ended questions, which asked the nurse was asked to list what she thought the patients most expected of her, and what she tried to give the patient.

Phase 2: The responses of the trained staff to the questionnaire in Phase Two were analysed by the author. These provided the basis for the rating scale used in Phase Three. The trained staff's perception of their role may best be summarised by classifying their view of the patients' expectations, and what they offered the patient in return. The author sumarised these as follows:

The patient's expectations. The staff's perceptions of the patient's needs fell into four areas.

1. Implicit support: The nurses believed that patients expected the nurse to be "understanding and friendly". The nurses also believed that patients' needed to feel they could "approach the staff at any time" and that staff would be "completely trustworthy". Most nurses described this need for 'support' in terms of gaining a "listening ear". One nurse suggested that patients' wanted to use her as a "sounding board for their thoughts and feelings".

2. Explicit support: nurses also thought that most patients expected "guidance, especially in making decisions". They also needed "information", about treatment, their illness, social security benefits, and routine organisation within the ward. Some patients also expected staff to help them "solve their problems for them", "act as a go-between with relatives" and sometimes to "referee disputes with family, especially husbands". Most nurses noted the patient's need to have "her confidence boosted".

3. Social: "Just talking" was cited by most nurses, especially "about neutral topics (nothing to do with illness)". Helping patients "do their hair" could be seen as a purely social activity, but probably also served a morale boosting function.

4. Health: the nurses also thought that most patients needed help with certain health-related activities, such as bathing and examining them

when they were in pain. In this category, one nurse thought that many patients wanted her to provide a "magic cure".

The nurses' expectations. Not surprisingly, the nurses' view of what they did for the patient most often, reflected the 'patient's needs' categories listed above.

1. Implicit support: The nurses saw "listening", within the context of a "trusting relationship", as important regular interactions. Some saw a need to provide "confidence and support", providing "reassurance as appropriate". Several nurses cited the need to make themselves "available" to the patient.

2. Explicit support: Most of the group described talking to patients as important. This took the form of "discussing her problems" and "helping the patient to solve problems" sometimes by "suggesting possible courses of action". Others emphasised responding to the patient's questions and providing "guidance as necessary".

3. Social: The only references to 'social interactions' were helping the patient to "structure her day" and "helping the patient with her personal appearance".

4. Health: A number of health-related interactions were described. The most common were "helping with personal hygiene" and helping the patient deal with symptoms of mental illness: the two areas cited were,

"reducing anxiety" and trying to "orient the delusional patient to reality".

Phase 3: The content of the two rating scales used in this phase (see Appendix 3 and Appendix 4) was developed from specific statements made by the nurses in response to the open-ended questions in Phase 2. The two scales represented

a) the nurses' identification of problems shown by patients suffering from manic depressive psychosis and

b) interpersonal techniques used by the nurses in the care of such patients.

Table 6.1 : Ranking of clinical problems by total score.

Rank	Problem	Total score
1.	Withdrawal	35
	Feelings of guilt	
2.	Poor concentration	34
	Poor personal hygiene	
	Poor food intake	
	Lack of communicative speech	
	Lack of positive thoughts	
3.	Delusional thoughts	33
	Tearfulness	
	Suicidal ideas	
	Lack of interest in appearance	
4.	Agitation	32
5.	Lack of motivation	30
	Hypochondriachal ideas	
6.	Constipation	29
7.	Hallucinations	26
	Insomnia	
	Immobility	
8.	Unco-operative behaviour	25
9.	Attempted suicide	14

Patient's problems: The total ratings given for each 'problem' were calculated by translating the A-E scale into 5-1 scoring. These totals provided an indication of the most commonly encountered clinical problems. These are summarised in Table 5.1

Interpersonal actions: The total ratings given for each interpersonal action were calculated as above. In order to simplify the nurses' ratings of the 42 possible responses, the data have been summarised under ten major areas. These represent the authors interpretation of the general 'class' to which each response belongs. These 'classes' are summarised below, with total scores for individual items noted in brackets (see Appendix 3).

1. Promotion of adaptive responses (items A,D,N1 & N3): This was the highest ranked class overall ($\bar{x}$=31.5). All four interactions received high rating from the respondents. Motivating the individual (N1) by "capitalizing on her interests" received the highest score (34) closely followed by involving the unmotivated patient (N3) "in a subtle manner" (33). The two other items in this class "encouraging normal conversation" (A) and "encouraging a response" in a group setting (D) also received popular support, with ratings of 30 and 29 respectively.

2. Provision of support (items E,I,P1,P3,S3): Providing the patient with support and reassurance through the nurse's 'use of self' was the second most popular class of interaction overall ($\bar{x}$ = 31.2). "Spending time with the patient listening attentively" was engaged in almost every day by all staff (rating total,35), with the use of the nurse-

patient relationship to "give the patient greater confidence" (34) used almost as often. In this category, fostering a good relationship in order to "provide *personal* support"(30), being supportive "if a patient appears indecisive, until a decision is made by the patient"(29) and explaining the patient's feelings of anxiety by relating this to her "nerves"(28) were used with roughly equal frequency.

3. Symptomatic relief (items B, R6 &T4): The three items in this class all received the same rating (30). If the patient expressed symptoms "in conversation" the nurse "would try to alleviate" them. If the patient "looked anxious" the nurse would "try to find out what the problem (was) and would deal with it herself". In the case of the suicidal patient the nurse would "listen to the content and attempt to alleviate her symptoms".

4. Modelling (items K, M2 & N2): Three statements described the nurse's 'modelling' of her own values and suggestions in an attempt to reassure or motivate the patient ($\bar{X}$=28.3). "Suggesting things for the (unmotivated) patient to do" (34) and in the case of the indecisive patient "suggesting a way to deal with the problem" (33) were used with equal frequency. Where a patient expressed anxieties about medication the suggestion that "some drugs can be helpful" (18) was not used as often.

5. Exploration (items C,F,G,H,P2,Q2,R1 & R2): Seven items dealt with assessment or exploration of the patient's thoughts or feelings

($\bar{X}$=25.7). Asking the patient directly "how are you feeling"(35) was used most frequently, followed by use of the personal relationship with the patient "to gather more information"(33). Using open-ended questions to establish "the root cause" (29) and trying to explore further "by asking more questions" when the patient asks "what is wrong with me?"(28) also were used often. "Actively listening to every conversation"(25), approaching the patient who looks anxious "asking 'is something bothering you?'"(24) and "asking various questions related to her outward signs of anxiety"(22) were used less often, with the use of "hunches" about how the patient might feel(18), used least often.

6. Problem-solving (items J,M3,R3 & T3): Four items dealt with different forms of 'problem-solving' ($\bar{X}$=25). "Discussing the pro's and con's of continued use of a drug"(30) was used most often. Reporting suicidal intent, but returning to work with the patient "to attempt to find a solution"(26) and giving "alternatives" to the indecisive patient (24) were used slightly less often. Engaging the anxious patient in "general conversation (letting her) bring up the subject if she wishes" was used least (20).

7. Persuasion (items O2,S1 & T1): Three items focussed upon 'reasoning' with the patient or using some form of persuasion ($\bar{X}$=23.6). Where the patient was suicidal, reasoning with her "for a period, then report(ing) the matter"(26) was used most often, with persuading unmotivated patients to participate in activities (23) and reasoning with the delusional patient (22) less frequent.

8. Direct advice (items L, M1 & Q1) : These items reflected the nurses' use of opinions and values to influence the patient directly ($\bar{X}$=15.3). The nurses' use of "her own values to influence problem solving"(18) and "giving an honest reply"(18) when asked "what is wrong with me?" by the patient, were used most often, but infrequently. Explaining the patient's drug treatment in terms of a "chemical imbalance" which required her to "keep taking the pills" (10) was used infrequently, by only some nurses.

9. Delaying (items O1, O3, Q4 & S2): These four items involved the nurse in either postponing an action, or 'buying time' ($\bar{X}$=14.8). Where a patient was unmotivated, and unwilling to participate in activity "draw(ing) back and pick(ing) another time"(25) was used often. Postponing involvement with the patient on the grounds that her"drugs were not at a therapeutic level"(16) or informing the distressed patient that "once your next blood results come through we may know (what is wrong with you)"(10) were used only infrequently, by some nurses. Where the patient was expressing delusional ideas "acknowledge(ing) the patient's speech" but failing to pass comment upon it (8) was 'never' used by most of the group.

10. Referral (items Q3,Q5,R4,R5 & T2): Passing information, or the patient, on to other members of staff, accounted for five items ($\bar{X}$=13.5). Collecting information to "pass on to the doctor"(20) was used most often, less often to a more senior nurse (16). Where the patient was distressed, referral on to a more senior nurse (15) was used more often than referral on to a doctor (10), which many nurses

said they would never do. Merely "acknowledging" delusional content and then reporting the matter (8) was hardly ever used by the group.

Discussion

Sub-study three attempted to describe the kind of problems trained nurses were required to deal with on the ward which was to be the base for the experimental project described in Part Three of the thesis and to clarify the kind of interactions which they used in response to these problems patients. The 'clinical problems' which the staff identified as most common on the ward reflect more severe affective disorder. The relative infrequency of tearfulness, complaints about physical ailments and sleeplessness, might support the view found in the literature, that these are more common in 'neurotic' depression, where the patient 'protests' more at her plight (Arieti, 1980). The nurses acknowledged greater contact with failure to attend to self-care, loss of interest, pessimism, concentration deficit, withdrawal, guilt feelings and delusional thought content, which are more typical of severe (or 'psychotic') depression and the depressive presentation of the patient with manic depressive psychosis.

The collection of interpersonal strategies, which comprised rating scale 1, was based exclusively upon the interactions described by the seven nurses in their response to the questionnaire used in Phase Two. Although these may not represent an exhaustive list of possible interactions with depressed patients, the 43 items represented the interactions reported by the trained staff members as examples of their 'routine' interactions. The scaling of the items provides an indication

of the relative frequency of use of these items by the trained staff overall.

In keeping with the findings from the review of the literature (Chapter 4) and the training syllabus (Chapter 5), most emphasis was given to interactions which capitalised upon the positive relationship between nurse and patient, especially where this was used to promote more adaptive behaviour, to boost the patient's confidence, or to provide a basis for exploration of the patient's feelings. Most of the nurses' attempts to *influence* the patient were indirect, using subtle encouragement, most often through 'normal' conversation individually, or in groups. The nurses emphasised the use of 'suggestion' rather than direction, which was eschewed in most cases. Directness was reserved for use in assessment, where the patient was invited to express her thoughts and feelings. The use of 'reasoning' was unpopular, except in the case of the suicidal patient, where most staff said they would immediately share this information but would also attempt to 'work with' the patient, in an attempt at resolution.

The most 'unpopular' items, which were used by only one or two nurses on a regular basis, involved avoidance of direct interaction with the patient. Most of the team rejected the idea of 'explaining away' the patient's symptoms by attributing them to her 'illness'. The idea of waiting for the patient to improve (naturally, or as a result of drug action) was unpopular, as was the idea of passing the patient on to the doctor.

Sub-study three attempted to define 'routine nursing care' on the experimental ward by developing a structured self-report format based exclusively upon the team's view of care. By using the frequency rating method, an indication of the most common (or most routine) interactions was gained. Because of the author's decision to base the final scale upon the interactions provided independently by the team, some 'omissions' were evident. For example, despite the emphasis upon 'poor self-care' no specific interactions in this area were reported as things the nurse did *most often* for the patient. Also by basing the final questionnaire solely on interactions defined by the individual nurses, a clear indication of the team's view of their 'appropriateness' was not gained. Despite having an opportunity to indicate "not applicable" in response to any item, this was used very infrequently.

The final picture reinforces the supportive, broadly facilitative view of care described in the literature review. Reference to any specific method, or techniques, for dealing with specific problems, was notably absent. Instead, the emphasis was upon a close involvement with the patient, most often on an individual basis, where the nurse tried to use herself to support and reassure the patient, provide a vehicle for exploration and problem solving and to maintain the optimum conditions for resolution and recovery to take place. The low frequency of referral of patients (or their problems) to medical staff suggests that the team accepted the patient as, largely, their responsibility.

Sub-Study 4: Survey of Scottish RMN Sample

Sub-study three reported above focussed attention upon a small group of trained nurses working in a ward which specialised in the care and treatment of women suffering from affective disorder in general, and manic depressive psychosis in particular. The data arising from sub-study three provided the basis for a description of 'routine nursing care' on that ward. In sub-study four reported here, a survey was undertaken of the perceived role of psychiatric nurses working in Scotland, using a random sample of registered mental nurses. This sub-study was undertaken in an attempt to compare, or contrast, the orientation to care expressed by the team in the experimental ward, with that of other psychiatric nurses working in other areas.

This survey was based upon the use of the Critical Incident Technique (CIT) which was developed by Flanagan (1954). The CIT involves the collection of observations of behaviour under specific circumstances, in order to assess their value as problem-solving strategies, and in the development of broad psychological principles. The procedure, which was developed by Flanagan (1954), has been used in a wide range of job and role analyses: from grocery store managers (Anderson and Nilsson, 1964) to psychiatric nurses (Cormack, 1983).

Method

Two kinds of observations are possible using the CIT. The observer may study either the behaviour of others or his/her own behaviour (self-report). Cormack's major study of the role of the psychiatric nurse used both kinds of observation. For the purpose of this sub-study, only

self-reported observations were invited for the following reasons. First, it was assumed that many of the interactions the nurse might have with patients suffering from affective disorder would take place in private, rendering them inaccessible to direct observation by an outsider. It was assumed also that the *outcome* of many interactions would involve responses which would be inaccessible to direct observation. Third, it was considered appropriate only to observe the behaviour of those nurses who had agreed to participate in the study. If the sample subjects recorded incidents involving their colleagues this might be seen as an intrusion into the colleague's professional and personal privacy. Finally, the research questions emphasised the examination of the nurse's *perception* of her role. This meant her *understanding* of what she did and why she did it. The subjects were asked to record examples of their interactions with patients, supported by personal observations on the outcome. No attempt was made to clarify whether or not these interactions occurred, or whether or not they were as the nurses described them.

Subjects

A random sample of registered mental nurses was sought by inviting the Directors of Nursing Services of the major Scottish psychiatric hospitals to draw a sample, at random, of registered mental nurses from their area of responsibility (see Appendix 5). 94 nurses were nominated, each of whom was invited to participate in the study. 61 nurses agreed to participate: 19 charge nurses and 42 staff nurses.

The study focussed specifically upon registered nurses in an attempt to simplify any conclusions which might be reached about the role of the *psychiatric nurse.*

Procedure

All communication with the subjects was undertaken by mail. Each nurse was sent a package containing:

i) a letter explaining the aim of sub-study 4 (see Appendix 6).

ii) thirty copies of the CIT record sheet (see Appendix 7) and

iii) a single A4 sheet which offered examples of appropriate reporting of incidents (see Appendix 8).

Each nurse was asked to describe any activity in which he did something for, to, or with a depressed patient (or his family), which he believed represented *effective* nursing. The record sheet required the description of the incident in five parts:

1. The events which led up to the activity (the stimulus conditions).
2. The nurse's action (the response).
3. The nurse's evaluation of the action (the perceived outcome).
4. The approximate date of the incident.
5. An indication of the grade of staff for whom the identified activity might be considered appropriate professional behaviour.

No further communication with the subjects took place. This report deals exclusively with the general classification of the incidents provided by the sample.

Results of Sub-Study 4

A total of 651 incidents was submitted: 78 incident reports (11.7%) were rejected on the grounds of illegibility or missing information. All CIT records were completed by the nurse in his/her own handwriting. In some cases, sections of the CIT record were left blank, or were not legible. In order to avoid unnecessary interpretation, these records were rejected from the final analysis.

Table 6:2 shows the breakdown of the incidents according to the two groups of registered nurses involved. The Table shows the total number of incidents, the arithmetical average and the range of CIT records submitted by each grade of registered mental nurse. Staff nurse subjects provided more than half of the data but fewer incidents on average.

Table 6:2 Distribution of Critical Incidents by Nursing Grade

	n	(%)	Tot. Inc.	(%)	$\bar{x}$	Range
Charge Nurse	19	(31)	284	(43)	11.8	1 - 30
Staff Nurse	42	(69)	367	(57)	6.4	1 - 30

The incidents were categorised using the classification system developed by Cormack (1983). Where more than one action was reported in the nurse's response, the central action was classified, and any remaining actions ignored. Cormack's classification system involved four main areas:

A: staff initiated therapeutic intervention;
B: administrative activity;
C: provision, planning and monitoring of physical care;
D: personnel function.

In the present sub-study, no incidents related to administrative activity or personnel function were presented by subjects.

Reliability of categorisation of CIT records. The incidents were classified initially by the author, after which 65 incidents were selected at random, 60 from area A and 5 from area C. This represented approximately ten per cent of the incidents already classified. Two independent judges were used to compute the inter-rater reliability (IRR) between the author and an external judge. Each judge was a psychiatric nurse, was known to the author, was familiar with the care of patients with affective disorder, but was not involved with the sub-study reported here. Each judge was provided with a photostat copy of the original incidents (n=65) selected for classification and a copy of Cormack's classification system. The judge was asked to code each incident using the classification system provided. IRR was computed as a function of agreement using the equation:

$$\frac{\text{Number of agreements}}{\text{number of agreements + disagreements}}$$

The percentage agreement between the author and judge A was 82%; between the author and judge B was 88%; and between judges A and B was 77%. ***Distribution of critical incidents.*** The distribution of the incidents across the two areas, their categories and sub-categories, is shown in Table 6.3.

Table 6.3 Classification of Critical Incidents

A: Staff Initiated Intervention

	n =
I: Uses self as a therapeutic tool	Total (336)
1. Makes self available to patients	38
2. Provides opportunities, or encourages patients to talk about their problems.	65
3. Is warm, understanding and sympathetic towards patients. Delivers care with sympathy and empathy.	15
4. Reassures patient. Encourages feeling of confidence, security or optimism.	56
5. Plans or encourages specific one-to-one relationship.	20
6. Recognises and encourages patient's individuality. Emphasises worth of patient and maximises level of self-esteem.	21
7. Encourages or provides social stimulation. Exposes patient to institutional and non-institutional social experiences.	41
8. Minimises patient's communication difficulties.	0
9. Recognises personal limitations when using self as a therapeutic tool.	4
10. Gives patient explanation of treatment, nursing care or nursing decisions.	31
11. Identifies patient's intellectual, spiritual or social needs or limitations.	5
12. Encourages patient to accept treatment or nursing care.	18
13. Maximises patient-staff trust.	5
14. Chooses appropriate nursing care.	14
15. Presents self as role model to patients.	3
16. Is consistent in delivery of care.	0
II: Makes therapeutic use of environment.	*Total (102)*
1. Encourages patient-patient understanding and relationships.	8
2. Encourages or facilitates patients playing an active part in treatment or self-care. Encourages independence.	50
3. Maximises patient's privacy.	9
4. Individualises patient care. Adapts the environment and routine or care to suit individual patients.	16
5. Introduces patients to ward rules, geography, staff or other patients.	1
6. Observes or supervises patients.	3
7. Makes therapeutic use of staff-patient or patient-patient groups.	15
III: Effectively deals or communicates with relatives.	*Total (34)*
1. Gives relatives correct explanation of, or information relating to patient's illness, treatment or nursing care.	19
2. Comforts relatives of dying patient.	0
3. Encourages or enables relatives to play an active part in care.	15

Table 6.3 (cont'd)

IV: Effectively responds to patient's pathological behaviour.	*(73)*
1. Responds to aggressive behaviour.	1
2. Establishes cause of pathological behaviour.	6
3. Focusses patient on reality.	10
4. Sets limits on patient's behaviour.	5
5. Responds to patient's anxiety, over-activity or over-stimulation.	25
6. Negatively reinforces pathological behaviour.	23
7. Anticipates and minimises, or prevents pathological behaviour.	3
V : Functions as part of a therapeutic team.	*(46)*
1. Complies with treatment programme or approach agreed by team.	6
2. Keeps self and others aware of clinical data relating to the patient. Obtains or encourages, when necessary, non-nursing care for the patient, for example from doctor or chiropodist.	40
C : Provides, plans for, or monitors physical care	***Total (60)***
I : Administers medications.	*(10)*
1. Administers medications carefully, accurately and as prescribed.	5
2. Ensures by observation or assistance that medications are taken.	0
3. Observes and monitors the side effects of medications.	5
II: Gives physical care.	*(50)*
1. Monitors physical health of patient.	2
2. Selects or initiates appropriate physical care.	35
3. Recognises personal limitations when delivering physical care.	1
4. Is aware of patient's treatments, physical needs and care.	4
5. Plans physical care or treatment in advance of it being delivered.	0
6. Promotes sleep.	0
7. Protects patients from a potentially dangerous environment. Removes potentially harmful items from the environment.	8

Each category, represented as a percentage of the total number of incidents (n=651), is presented in Table 6.4.

Table 6.4 Areas and Categories as a Percentage of Total Incidents.

	Title	% Total Incidents
Area A :	Staff initiated intervention	(90.7)
Category	I: Therapeutic use of self.	51.6
	II: Therapeutic use of environment.	15.6
	III: Deals with or communicates with relatives.	5.2
	IV: Responds to patient's pathological behaviour.	11.2
	V: Functions as part of therapeutic team.	7.1
Area C :	Provides, plans for or monitors physical care	(9.3)
	I: Administers medication.	1.5
	II: Gives physical care.	7.8
		100.0

Therapeutic use of self. In this category, more than one-third of the incidents involved the sub-categories *encouraging the patient to talk* (19.3%) and *providing him with reassurance* (16.7%), with another 11.3% of the incidents involving the nurse *making herself available to the patient*. *Social stimulation* involved encouraging patients to participate in social activities, or accompanying them on social trips or visits home (12.2%). *Explanation* of treatment (9.2%) and *encouragement* to accept treatment (5.4%) involved drug therapy and ECT only. *Maximising the patient's self-esteem* (6.3%) and *planning one-to-one relationships* (5.9%) were reported infrequently, given the nature of the patient population. People suffering from most forms of affective disorder are more likely to project negative views of themselves than any other sub-population in psychiatry (Sackheim and Wegner, 1986; Rush *et al*, 1986), suggesting that the 'maximisation of self-esteem' would represent a prime nursing objective. Patients

suffering from more severe forms of affective disorder also display communication difficulties which suggests that one-to-one relationships might play a central role in enabling communication about thoughts and feelings. Similarly only five incidents each were classified under *maximising trust* and *identifying social, intellectual and spiritual needs*. Although demonstration of sensitivity and empathy was represented infrequently (4.5%), this may be a function of the self-report format. Respondents may have been reticent about acknowledging their expression of sensitivity.

Therapeutic use of the environment. Almost one-half of the incidents in this category involved the *promotion of independence* (49%): *encouraging patients to care for themselves*, or *providing minimal assistance to unmotivated or withdrawn patients*. 15.6% of the incidents dealt with individualising care: *providing individual patients with recreational materials*; arranging the *use of telephones or side-rooms and special equipment* (such as large print books). *Groupwork* incidents dealt with conversational groups for patients, or *staff-patient meetings* where ward business was discussed (14.7%). In this category only 7.8% of the incidents dealt with the *promotion of individual contact and understanding between patients*; and 8.8% with maximising privacy.

Deals with or communicates with relatives. More than half of the incidents in this category dealt with nurses *providing information* to relatives *about the condition or treatment of the patient* (56%). The remainder involved *encouraging the relative to take some part in the*

patient's treatment programme: such as supporting the patient when on pass or reinforcing self-medication. No incidents were classified under Cormack's sub-category 'comforts relative', since this specifically identified the relative of a dying patient. Where interactions with distressed relatives were involved, these were classified under 'giving information' since they involved reassuring the relative by giving information about treatment, side-effects and future plans.

Responds to patient's pathological behaviour. *Most incidents in this category involved responding to expressions of anxiety (34%) and overactivity, or negatively reinforcing pathological behaviour (32%).* In the former, nurses appeared to respond spontaneously to such problems: spending time with the patient, distracting her, or arranging other diversional activities. In the latter, the intervention appeared more formal: teaching relaxation, or promoting concentration through the allocation of simple tasks. Where the nurse oriented the patient to reality (13.7%) this always involved helping her to identify personal assets and attributes as distinct from failings and problems. Again, given the role which negative self-evaluations could be expected to play in most depressive illnesses, the frequency of anticipatory or preventitive action (4%) seems low.

Functions as part of a therapeutic team. Only a small proportion of the incidents classified under this category involved an emphasis upon *compliance with a set 'team approach'* (13%). Most of the incidents involved inviting medical staff to examine patients, or requesting specialist opinion (87%). Of the incidents so classified, none referred

specifically to the nurse keeping himself, or, others, 'aware of clinical data relating to the patient'.

Administers medication. Only ten incidents overall were classified under this category. Five referred to the administration of a depot injection and five to taking a blood sample for drug analysis.

Physical care. The selection and initiation of *appropriate physical care* accounted for 70% of the total: washing and dressing very retarded patients; tube-feeding or giving "build-up" drinks to anorectic patients. The absence of any reference to the promotion of sleep is notable, given the prevalence of insomnia in descriptions of the characteristics of affective disorder in general (Ingram, Timbury and Mowbray, 1976; Kendell, 1983). In view of the likelihood of suicidal behaviour, the low frequency of reports concerning the protection of the patient from danger (16%) is also notable.

Discussion

In sub-study four, 61 registered psychiatric nurses, selected at random from Scottish psychiatric hospitals and units, described their perceptions of their interactions with patients diagnosed as suffering from affective disorder in general. The sample were asked to describe only interactions which they considered to be examples of *effective* psychiatric nursing care. A total of 651 incidents were classified under two areas, seven categories and 45 sub-categories, previously reported by Cormack (1983). Analysis of these incidents suggests that the sample saw their role primarily in terms of 'psychotherapeutic

intervention'. One third of all incidents were represented by actions involving the nurse making himself available to the patient; encouraging her to express thoughts and feelings; demonstrating warmth, sympathy and understanding; reassuring as necessary; in the context of a close relationship; in an effort to enhance the patient's self-esteem. Less than ten per cent of the incidents dealt with physical aspects of care, including medical treatment. In the remaining incidents (57%) the nurses responded to the everyday problems of the patient and her family and facilitated treatment using an informal 'psychosocial' model. From the data it would appear that as far as the care of the patient with affective disorder is concerned, the nurse sees his role primarily in social or psychosocial terms.

Sub-study four suggests that the sample reflects many of the ideas about the nurse's role projected by the General Nursing Council for Scotland (1978) in their *Schemes for Training*, which guided syllabi of training implemented since 1982. The nurses appeared to function in a highly supportive capacity, as the General Nursing Council for Scotland suggested, expressing this through friendly interest and concern. As noted earlier, one third of the incidents were represented by 'confiding relationships'. The sample's most popular 'therapeutic methods' involved *listening* to and *reassuring* distressed patients; *suggesting* social, occupational or self-care activities; and using *persuasion*, where patients were reluctant to comply with treatment (medical or otherwise). These interpersonal techniques were noted specifically in the *Schemes for Training* document described earlier. The interactions appeared to be based upon relatively 'informal' assessment

of the patient. Almost all the interactions described spontaneous, or reactive care, determined by the patient's immediate presentation. It is not possible to judge whether specific incidents were part of a formal care plan. It is clear, however, that reference to planning of care was negligible. However, this may be a function of the kind of information requested. It would appear also that most nurses exercised their role in relative isolation from colleagues, whether fellow nurses or other professionals. Although this may also be a function of the data collection technique, reference to asking for assistance from colleagues and collaboration with psychologists and occupational therapists, was minimal. Reports of involvement in formal therapeutic activities, such as group or individual psychotherapy, also were infrequent.

Some reservations can be expressed about these findings. First, it would appear that most of the incidents reflect nurses' *interaction* with patients, which should not be confused with nurse-patient relationships. Interaction implies a reciprocal 'acting' of one upon another. In a relationship. however, the mutual exchange is assumed to be deeper, more meaningful, perhaps more honest. In many of the incidents the nurse *instructed* the patient directly, or *responded* spontaneously to her presentation. In both cases, an interaction took place. It is not clear, however, whether this involved the mutual exchange of feelings and meaningful or honest discussion, which one would expect within a close, confiding relationship. Relationships may have taken place. However, it is not clear exactly what was their nature or function. An illustration of the author's uncertainty about

the nature and function of these interactions is provided in the following reported incident, which has been abbreviated slightly:

> The patient was sitting by her bedside crying with her head buried in her hands. I approached her and drew the curtains around the bed and asked her why she was crying. She said that she thought would be hospitalised for life. I put my arm round her and promised her that she would get well and would go home.

The subject commented that any grade of staff could give this kind of reassurance, providing that they are aware "with certainty (*sic*)" that the patient will go home. The nurse's response appeared to meet the patient's immediate need for reassurance: the conclusion of this incident noted that "the patient smiled and appeared happier as a result". Although the incident appears to describe the nurse supporting a patient experiencing acute emotional distress, one might ask what kind of relationship is the patient beginning to establish with the nurse.

Much of the care which was reported is unidirectional. The nurses gave advice, instructions, suggestions and used persuasion and reassurance, all of which was received by the patient. There was little explicit indication of any collaboration between nurse and patient, except where physical problems, such as dressing or feeding difficulties, were identified.

Sub-study four aimed to describe nurses' perception of effective nursing care. It is not possible, or indeed appropriate, to challenge any of the examples provided in the incidents. However, it should be noted that some of the descriptions of 'effective' outcome, represented

no more than the nurse's subjective opinion, where it was reported that the patient "appeared" or "seemed" to be "better/happier/more cheerful". More importantly, it is not clear whether immediate 'positive consequences' might not have signalled the beginning of longer-term problems. For instance, in the example quoted on the previous page, although the subject described the patient as appearing to benefit from the reassurance given, if such a 'need for reassurance' was met repeatedly, the nurse's action might be described as fostering dependency.

Sub-study four is limited by three methodological issues. First, the critical incident format focussed exclusively upon self-report. As a result, the data produced reflect only self-perception, rather than observations of the nurse at work. The assumption that each nurse in the sample had the capacity to be objective about his own work requires careful consideration. The study used Cormack's (1983) classification system, which had been subject to critical examination in a much larger study. Rather than develop a new classification system, which might have been more specific to the care context of affective disorder, the validity of Cormack's areas, categories and sub-categories within the setting of care of the patient with affective disorder, was assumed. The classification system used described nursing interventions and activities relevant to the care of patients in general. This system noted specifically the nurse's reponses to aggressive behaviour, anxiety, over-activity, and over-stimulation, but did not describe specific responses to patterns of behaviour more characteristic of affective disorder. It could be argued that since the focus of the sub-

study was upon a specific population, rather than psychiatric patients in general, a specific classification system should have been adopted. Third, it was intended that the subjects would represent a random sample of registered mental nurses working in Scotland. However, more than one third of the Directors of Nursing Services invited to participate in drawing the sample, failed to respond. Although the instructions regarding the procedure for recruiting the sample subjects were explicit, there is no guarantee that the Directors of Nursing Services did not select nurses whom they thought would reflect positively upon their hospital. Given also that the sample comprised less than two thirds of the nurses invited to participate, it could be argued that a proportion of the sample were nurses interested in research and the care of the patient with affective disorder, or were otherwise 'motivated' to participate in the sub-study. In view of these reservations, it should not be assumed, therefore, that the description provided by the sample, is representative of the general orientation to care of this population, of psychiatric nurses in Scotland. Despite these reservations, however, it is clear that the actions and interactions described by the sample do not differ greatly from the role recommended by the General Nursing Council for Scotland (1978) in their *Schemes for Training* document.

CHAPTER 7

DISCUSSION OF PART ONE

In Part One the historical development of the psychiatric nurse was reviewed in an attempt to locate psychiatric nursing in relation to both psychiatrists and nurses working in other fields of health care. This review noted how psychiatric nurses have been influenced by the example of medical colleagues. The history of psychiatric nursing is, therefore, very much a reflection of the history of psychiatry. It has been noted by Cormack (1976), among others, that this dependence upon medical authority leads nurses to define their role in the ideological image of the psychiatrists with whom they work. Consequently, the range of conceptual models which nurses have manipulated in an effort to clarify their approach to patient care, often reflected the philosophical orientation of the psychiatrists who were the authority figures in the clinical setting.

The review of the psychiatric nursing literature in Chapter 3 illustrated the range of attitudes and orientations towards care, represented in the published literature. This heterogeneity is evident even where a specific population, such as patients with affective disorder, is considered. Here, as in psychiatric nursing in general, the recent trend has been towards the development of a more structured interaction with the patient, using the problem-solving format of the process of nursing. This approach can be used as the medium for the application of any theoretical paradigm of affective disorder, from the

narrow reductionism of some biophysical models, to the eclecticism of psychosocial models such as cognitive therapy.

The review of the Scottish psychiatric nurse training programme, presented in Sub-study 1 (The RMN Curriculum) in Chapter 5, is by now somewhat dated, since the outline syllabus was prepared in 1978. Although the author tried to represent all the comments made in the General Nursing Council for Scotland's (1978) *Schemes for Training* document regarding affective disorders, the resultant review may well reflect no more than the author's interpretation of selected statements related to the training of the mental nurse. The critical examination of the ideological orientation of the written examination for the mental part of the register, presented in Sub-study 2 (The Written Examination) may, however, provide a clearer indication of the governing body's view, past and present, of the skills and attitudes necessary to care for the depressed patient. The questions studied represented *all* those questions dealing with affective disorder which appeared in the final examination papers over a ten year period. The classification of these questions could be criticised on the grounds that the format used was developed by a small convenience sample and that the panel of judges represented a further convenience sample, all of them known to the author. The high degreee of agreement between each of the 17 judges may reflect a weakness in the classification format, or may suggest an ideological orientation common to the panel itself.

The two sub-studies, reported subsequently, provided a highly specific and a general overview of nurses' perceptions of their work with

depressed patients. In Sub-study 3 (The Role Of The Trained Nurse In The Experimental Ward), a small nursing team described their orientation towards women suffering from manic depressive psychosis, within the context of a specialised unit. The design of this sub-study initially allowed the nursing team considerable freedom to describe their care of patients on the ward. However, in the subsequent stages the author alone was responsible for isolating 'significant' comments and for the development of the two scales which were used to quantify the frequency of different interactions and clinical problems. Although material which formed the basis for the questionnaires and scales used in this sub-study was drawn entirely from statements made by the nurse subjects, the potential for experimenter bias, in the form of the author's selection and rejection of different comments, should not be overlooked. In Sub-study 4 (Survey Of Scottish RMN Sample), Scottish nurses described their care of patients suffering from affective disorder in general, across a range of clinical settings. Consideration of all the data presented, from the literature review to the sub-studies, suggests that a general set of principles is used in the nursing management of all patients suffering from affective disorder. The therapeutic 'use of self' *prescribed* in the literature was emphasised strongly in both sub-studies (3 and 4) reported in Chapter 6. These nurse subjects stressed their interest in promoting more adaptive behaviour, including problem solving, as well as in encouraging the patient to express thoughts and feelings. Less than ten per cent of the survey sample data in Sub-study 4, related to physical care, with the ward sample, in Sub-study 3, failing to specify directly any interactions in this area. Both groups acknowledged these as 'need'

areas, but emphasised other aspects of their interpersonal relationships with patients suffering from affective disorder. This may suggest an informal scaling of different interactions, in terms of perceived importance. Where physical care was cited in Sub-study 4, the Survey Of Scottish RMN Sample, the subject commonly suggested that 'any nurse' could fulfill this need, whereas relationship building and symptom relief commonly were related to the work of senior, or experienced, staff members.

The published literature, including the training syllabus, paid only minimal attention to the use of specific therapeutic methods in the care of patients with affective disorder. The Schemes for Training document (General Nursing Council for Scotland, 1978) emphasised the nurse's *supportive* role in any formal 'therapy', whereas the examination questions appeared, in the view of panel of judges, to invite a 'medical-expressive' nursing role. Although the clinical nurses studied in Sub-studies 3 and 4, emphasised 'therapeutic' relationships with patients, these were generalised and did not emphasise any specific theoretical model. Of most significance, perhaps, was the finding in Sub-study 3 (The Role Of Trained Nurses In The Experimental Ward), that 'routine nursing care' of the patient with manic depressive psychosis, showed no marked differences from the care of patients with affective disorder in general, reported in the survey sample in Sub-study 4. Alhough patients with manic depressive psychosis may present with more severe 'problems', the nurses' response to these phenomena involved interactions similar to those recommended for all patients with affective disorder: support, reassurance, encouragement

and some advice, against the background of an assumed 'personal relationship' between nurse and patient.

Despite this person-centred approach, individualised care for specific patients, or in response to specific clinical problems, was not emphasised. Although some of the training programmes developed from the General Nursing Council for Scotland's 'outline syllabus' emphasise the process of nursing and conceptual models of nursing, the nurses in the clinical sub-studies (3 and 4) did not describe the selection of either patient-specific, or problem-specific, care interventions. Indeed, the data suggest that all patients receive broadly similar patterns of care, irrespective of the nature or severity of presenting 'symptoms'. If one takes the view that illness is the patient's experience (Pilowsky, 1975), then no two people experience the same illness in the same way and, therefore, no two 'care plans' should be similar. In keeping with this person-centred approach, Wilson-Barnett has commented that nurses need appreciate the patient's understanding of illness *and* her beliefs and preferences for treatment and care:

> ...mutual goal-setting...is at the very heart of individualised care, bridging the gap between medical science and the patient's value system (Wilson-Barmett, 1985, p.36).

Although it would be wrong to conclude that the nurses in the two clinical sub-studies did not use a person-centred approach to care, evidence of 'mutual goal-setting' was absent and, as noted, all patients were treated in broadly similar ways. Not all nursing theorists, however, support Wilson-Barnett's view of the 'uniqueness' of the patient and the need for individualised care. Peplau has

recalled recently Sullivan's dictum that "we are all more alike than not"(cited by Peplau, 1987: p. 208). As psychiatric nursing begins to establish the foundations for a 'science of care', the *relations* which exist between nurses and patients might well be represented by *universal, regular, common* elements, which fulfill the definition of such phenomena as 'effective', or 'appropriate' nursing care. Peplau has suggested that in order to present appropriate care nurses must first generate inferences about the patient's behaviour, applying:

> ...theory as professionally oriented intellectual operations, in order privately to intepret the data (observed behaviour)"(Peplau, 1987: p.202-3)

If one infers that there are differences between severe affective disorders which 'psychotic' patients appear to *accept*, and milder affective disorders from which 'neurotic' patients seek to *escape* (Arieti, 1980), then different forms of nursing intervention may be appropriate.

It should not be forgotten that, in the field of psychiatry, nurses are faced by many dilemmas regarding treatment, not least of these being an implicit requirement to accept, the treatment model of the medical practitioner (Cormack, 1976). In the critical incident survey (Sub-study 4),the patient's anxiety over drug therapy or ECT was described. In every case, the nurse attempted to alleviate these anxieties by reassurance and the instillation of hope in the success of the treatment. No nurse reported assisting the patient to express formally a request to discontinue, or to decline the offer of, such treatment. In the experimental ward sub-study (3) the most 'liberal' interaction in this regard involved discussing the "pro's and con's of drug

therapy". Wilson-Barnett (1984) suggests that if nursing is to become *complementary*, rather than *subordinate* to medicine, nurses may need to:

> ...communicate the patient's wishes to discontinue treatment, or their views which do not concord with the doctor's judgement (p.36).

Clearly, the nurse's role as the patient's advocate is, as yet, at an early stage of development. However, such dilemmas are highly pertinent to the care of depressed patients. In this regard Peplau (1986) has observed that:

> ...the biomedicalization of psychiatry will force nurses to choose between continuing to develop their own forms of therapeutic work or using their work merely to monitor the results of psychiatric treatment (p.328).

The data drawn from the the literature review and the training syllabus appears congruent with the practices described by nurses in the two clinical sub-studies. In the absence of any sizeable nursing research literature, describing the appropriateness or effectiveness of specific care practices, with specific patient 'types', it would appear that nurses are most comfortable 'straddling' the psychosocial world which psychiatric nurses and their patients have always inhabited, and the biomedical world of psychiatric treatment described by Peplau.

PART TWO

CHAPTER 6

LOCUS OF CONTROL IN MANIC DEPRESSIVE PSYCHOSIS :

INTRODUCTION TO AND OVERVIEW OF PART TWO

In Part Two of the thesis, patients suffering from manic depressive psychosis will be described from a specific psychological perspective. As noted in Chapter 1, several studies have reported the interactive effect of environmental events and affective disorder of various kinds. Although the position is unclear, there are indications that the distinction between 'reactive' or *neurotic* depression, and 'non-reactive' or *endogenous* depression, may be misleading. It has been suggested that even sub-groups of affective disorder (such as manic depressive psychosis) which once were viewed by Kraepelin as originating wholly from biological origins, may be a function, at least in part, of the influence of external events and of their psychological interpretation by the patient.

Due largely to the strong biomedical research tradition into the aetiology and treatment of manic depressive psychosis, relatively little psychological data have been generated from this sub-group ofthe affective disorder population. In the second part of the thesis the following research question is posed:

How does the patient suffering from manic depressive psychosis perceive herself in relation to her condition, or illness?

In Chapter 9, three models of depression are reviewed, each emphasising the role of cognition as a mediational process between external (life) events and the resultant symptoms of depression. This review concludes with a specific consideration of the key constructs, attribution and locus of control.

In Chapter 10, sub-study five examines the beliefs expressed by manic depressive patients, using two standardised locus of control scales. This study attempts to clarify the 'psychological' picture of manic depressive patients, by comparing these subjects with normative samples, also making a comparison between subjects with a history of depression-only, and subjects with experience of depression and mania.

In Chapter 11, sub-study six is reported. This was used to develop a brief locus of control scale, which aimed to measure the depressed patient's view of herself, as a chronic sufferer from depressive illness. The final chapter in this section reviews the sub-studies of this specific depressive population, against the background of contemporary research and psychological model-making of depression in general.

CHAPTER 9

COGNITIVE MODELS OF AFFECTIVE DISORDER

The complexity of the definition of affective disorder was noted in Chapter 1. Despite support for some form of genetic transmission, promising enquiries into cerebral amine metabolism, and various endocrine function and electrolyte metabolism hypotheses, the theoretical jigsaw of the causation of specific affective disorders, such as manic depressive psychosis, is still incomplete. Identical twin studies show that some patients suffering from manic depressive psychosis may be unipolar, whilst others are bipolar. Furthermore, the one hundred per cent concordance between monozygous twins, which might be expected from a genetically transmitted disorder, has not been demonstrated (Bertelsen *et al.*, 1977). Kendell has commented that enviromental influences of one kind or another must play a part in the aetiology of affective psychosis (*sic*):

> ...if they did not the concordance between monozygous twins would be close to 100% and the illness would develop at a similar age, and pursue a similar course in both (Kendell, 1983b, p. 307).

The role of environmental factors has been implicated in the genesis of affective disorder at least since Freud's publication of *Mourning and Melancholia* in 1917 (Freud, 1957). Most authorities agree, however, that if singular traumatic events (like early parental loss) have any effect, it is likely to be weak and not restricted to affective disorder. The effect of other 'loss states', such as childbirth, where the foetus breaks its special link with the mother, and hysterectomy,

where the capacity to bear children is lost, have also been studied but relate only to certain kinds of affective disorder, in some women. Within psychological theory, there exist a number of conceptual models, each purporting to explain the 'etiology' of affective disorder, serving the basis for various schools of psychotherapy. Although all deal with one form of experience or another, over the past thirty years increasing attention has been paid to the process of perception and judgement as correlates of depressed affect (Beck and Hurvich, 1959). More recently, studies have focussed upon the patient's perception of events which might represent significant 'stressors' or potential threats to psychological homeostasis. A psychotherapeutic model has emerged from this emphasis which, given its focus upon the relationship between thinking and mood, can be called 'cognitive'.

Three Cognitive Models of Affective Disorder

Beck was one of the first writers to challenge the view that affective disorder involved *only* emotional elements. In particlar, he rejected the notion that any impairment of thinking *resulted* from affective disturbance (Beck, 1963). Since no formal evidence of abnormalities in cognitive processes could be detected through psychological testing, thinking style was assumed to have no bearing upon the genesis of affective disorder (*cf.*Schafer, 1948). Several 'cognitive' models have been described in the past decade, each postulating a relationship between specific cognitions and depressed affect. The theories summarised below represent theoretical formulations from a *sociological*, *psychological* and *psychiatric* viewpoint. Each suggests that emotional reactions are mediated, at least in part, by thought -

a view which has much in keeping with the much older tenets of Stoic philosophy. Despite this common theme, however, each model expresses differences which influence their practical application in a psychotherapeutic context.

The social model

Affective disorder has long been associated with the concept of *loss* (*cf* Freud, 1957 & Bowlby, 1971;1973). A relationship between certain losses (such as death of a parent, divorce or child leaving home) and the onset of affective disorder, has been observed by a number of researchers. Brown and Harris' sociological study of women in a London borough, whom they described as suffering from various kinds of 'depression', extended this concept by identifying the role of *social status* as a determinant of the patient's reaction to such critical life events (Brown & Harris, 1978). By rating the *contextual threat* of events and the degree of long-term difficulty, they showed that chronic life problems, such as bad housing and problems with in-laws, represented a *special* kind of life event which was more common in 'depressives' than controls. They also identified four *vulnerability factors* which, although not a direct precipitant of affective disorder, heightened the risk where critical life events were in evidence. These were: the early loss of mother; involvement in the care of young children; absence of a confiding relationship; and lack of a full or part-time job. A later replication of the London study in Canada confirmed the relationship between threatening life events and depression (*sic*), in the absence of a confiding relationship, but

failed to support the role of social class, employment and parental status (Costello, 1982).

In Brown and Harris's view those findings provided the basis for a cognitive model of depression (*sic*) which they acknowledged was no more than "speculative" (Brown and Harris, 1978 p.233). They suggested that the patient's *appraisal* of her world was of primary importance. Women become demoralised when they are unable to fulfill patterns of behaviour which are linked to particular role identities. In the presence of severe or longstanding life problems, the fulfillment of 'plans of action', related to her role, is obstructed and the woman is deprived of sources of reward or value. Although their hypothesis reflects the symbolic loss most commonly associated with Bowlby's ideas (Bowlby, 1971 & 1973), parallels exist also with the reinforcement-loss hypothesis of some behavioural formulations of affective disorder (*cf.* Lewinsohn, 1974).

Brown and Harris (1978) also speculated about the role of the woman's perception of her control over her circumstances, quoting Melges and Bowlby (1969):

> ...loss may be of *faith in one's ability* to attain an important and valued goal (emphasis added).

When the woman cannot conceive of ever restoring her source of value, she experiences a feeling of hopelessness, especially where memories of some previously unresolved event are reactivated. The vulnerability factors have the effect of lowering self-esteem and generating pessimism over her ability to control her world and to restore her

source of value. Brown and Harris speculated that low self-esteem would generalise this sense of hopelessness, which would lead to *denial* in an attempt to suppress the painful emotions, their inevitable release taking the form of depression (*sic*). Although Bebbington (1985) has noted the apparent conflict between the *appraisal* and *denial* of hopelessness in Brown and Harris' model, empirical evidence for such co-existence has been offered (Horowitz *et al.*, 1980).

The psychological model

The concept of hopelessness noted in the discussion above, was addressed also by Seligman's 'learned helplessness' model. Extrapolating from experiments involving the administration of inescapable shocks to dogs (Seligman & Maier, 1967), the hypothesis was proposed that the depressed (*sic*) person fails to learn adaptive ways of dealing with painful events, learning *helplessness* instead. Repeated failure to control her environment results in construing herself as 'helpless', unable to alter this unsatisfying state of affairs. Since she believes that her behaviour lacks meaning, she becomes passive, expressing feelings of misery and hopelessness. Seligman first saw this model as highly specific, addressing only the person who was:

> ...slow to intiate responses, believing himself to be powerless and hopeless, and (who) sees his (sic) future as bleak (Seligman, 1975: p.81).

The model dealt with specific, rather than generalised pessimism : "specific to the effects of one's own actions"(Seligman,1975: p. 86). Three deficits were also emphasised: failure to control events resulting in a *motivational* deficit; erroneous expectations of repeated failure in the future representing a *cognitive* deficit; and

the *emotional* deficit experienced in depressed affect. Responding to criticisms of the model's animal roots by Blaney (1977) and Depue & Monroe (1978), reformulations have been presented by Abramson *et al.* (1978) and Miller and Norman (1979).

The reformulated model of Abramson, Seligman and Teasdale (1978) places greater emphasis upon *attribution*. In their view, if someone fails to control a specific outcome they tend to ask *why* this is so. The answer determines how widespread and longlasting will be its effect on the person's self-esteem. By introducing the *locus of causality*, the reformulated model distinguishes between the person's perception of the task as impossible and the perception of the person (self) as incompetent. If the person believes that nobody could have controlled the situation, a feeling of *helplessness* will ensue. If, however, the failure is attributed to a deficit within herself, she will feel *incompetent*, producing not only a lowering of mood but also of self esteem.

Acknowledging the deficits of the original model, Abramson and her colleagues describe several dimensions of attribution in an attempt to explain the pervasiveness and chronicity of depressed affect. Helplessness, they suggest, will be pervasive and chronic if the person attributes failure to *stable* factors, which are seen as unlikely to change across time; or to *global* factors which are seen to apply across a wide range of situations. The dimension of *controllability* is further postulated as an explanation of guilt: if the person thinks that she could, or should, have controlled the situation she is likely to feel

guilty. Abramson *et al.* suggested that such feelings are a subset of low self-esteem.

These authors emphasise that their attributional model provides *sufficient*, but not necessary, conditions for depression (*sic*). The reformulated model responds to many of the criticisms of Seligman's original theory, offering an account of the persistence of depressed affect over time and of how this might generalise across situations by interpretations of experience. In this sense it has been described as elegant, precise and sufficently complex to account for people's response to their circumstances (Bebbington, 1985).

The psychiatric model

Beck's cognitive model stemmed from his disenchantment with traditional psychoanalysis, in particular with the idea that depression (*sic*) arose from a need to suffer (Beck, 1967). The model had a number of influences: individual psychology (Adler, 1927); personal construct theory (Kelly, 1955); and rational emotive therapy (Ellis, 1962). All of these emphasised the role of the patient's construction of reality. Beck extended these earlier concepts in a cognitive model which was based upon systematic clinical observation and experimental research (Beck and Greenberg, 1974; Beck *et al.*, 1980).

In Beck's view, *psychopathology* is present when a person engages in distorted thinking which deviates from what most people would consider to be a realistic way of interpreting reality. This view is important in terms of its definition of affective disorder in medical and

normative terms (*cf.* Sedgwick, 1978). Beck saw three specific classes of distorted thinking in depression (*sic*), which he called the 'cognitive triad': a negative view of self; negative expectations of the environment (or world); and negative expectations of the future (Beck, 1970). The depressed person sees the world as making unacceptable demands, putting insurmountable obstacles in her way. She also saw herself as inadequate, diseased or defective; expecting that the future will bring only further difficulty, suffering and failure.

Specific 'schemas', or belief systems, were identified within the model. It was hypothesised that these had their origins in childhood experience. When a critical life event is encountered, these schemas - which process the experience of the event - stimulate particular, d*ysfunctional* interpretations of the event:

> A schema may be inactive for long periods of time but can be energized by specific environmental inputs (Beck *et al*, 1980, p.13).

Such "prepotent dysfunctional schemas" can be triggered by a range of inappropriate events and, in depression (*sic*), can lead to the loss of control over thinking processes. In severe depression (*sic*), the patient's dysfunctional thinking becomes autonomous, operating independently of external events. The role of loss is also noted:

> ...after experiencing loss (either as the result of an actual, obvious event or insidious deprivations) the depression-prone person begins to appraise his experiences in a negative way (Beck, 1976: p.129).

The theory suggests that a number of discrete thinking errors, involving faulty information processing, maintain the cognitive triad

and the supporting dysfunctional schemas. Beck has observed how the depressed individual isolates negative events from their natural context (employing the 'thinking error' of *selective abstraction*); the negative view of the event is supported, despite evidence to the contrary (*arbitrary inference*); single negative events are used to prove a general rule (*overgeneralisation*); events may be scaled up or down in value or potency in order to demonstrate failure (*magnification or minimisation*); events are seen as highly personal despite the absence of evidence to support this (*personalisation*); and the perception of events involves the use of highly polarised values (*dichotomous thinking*).

Beck described such a style of thinking as "primitive", rather than moderate, multidimensional and "rational". Such thinking, he argued, involves attributions of self-blame, which carry a highly absolutist as well as moralistic tone. Depressed affect is maintained across time by the persistent use of negative thinking, stimulated by dysfuctional schemas which, in turn, stimulates further emotional distress.

A review of the cognitive models

Four discrete attitudes were evident in these models: a lowering of self-esteem; helplessness or hopelessness; self-blame;and the concept of 'imposition' or 'burden'. The role of self-esteem was addressed by all three models. Brown and Harris suggested that this was linked to ideas of self-confidence and mastery, ideas which were echoed in Beck's "negative view of self" and Abramson's locus of causality, where the person perceived herself as incompetent. The concept of hopelessness or

helplessness existed in very broad terms in the models of both Beck and Brown and Harris. Garber *et al.* reinforced the value of Abramson *et al.*'s view that helplessness can function as a distinct theme, noting that:

> ...it is possible to be helpless without being hopeless, but it is not possible to be hopeless without simultaneously being helpless (Garber *et al.* 1980).

Self-blame, prominent in Beck's model, is not stressed by Brown and Harris and is translated by Abramson *et al.* into the concept of *controllability*, albeit without the the moral tone engenderered by the imperative nature of Beck's "shoulds and musts". Finally, both Beck and Brown and Harris emphasise the role of 'imposition': the person who sees herself as a failure is (therefore) a burden on others.

The common thread running through these three formulation of affective disorder is reinforced by Bowlby (1985), who noted that Seligman's learned helplessness theory is highly compatible with his own concept of loss in the genesis of depressive disorder (*sic*)[p.247] and also that Beck's theory of depressive disorder (*sic*) "is cast in the same mould" as his own view of the role of cognitive biases (p.249). Bowlby's studies have extended Freud's original research on loss in *Mourning and Melancholia*. He noted that the helplessness described by Seligman is very similar to the helplessness described by mourners. However, despite his acknowledgement that Beck's data are explicable by his own theory, he emphasised the limitations of Beck's model, noting that no attempt was made to explain the actual function of childhood experience in the generation of negative schemas. Bowlby (1985), however, reserved most support for the social model proposed by Brown and Harris which he viewed as "of great importance for an understanding

of depressive disorders *(sic)*[p. 256]. Bowlby's psychosocial model, and by implication those other psychological models he endorsed, emphasised the role of the patient's relationship to life events in the etiology of affective disorder.

It could be argued that the three theoretical models reviewed here relate specifically to 'psychological' forms of affective disorder, where the 'depressive' state is manifested as a reaction to environmental, or psychosocial, events. If one assumes that 'biological' forms of affective disorder, such as manic depressive psychosis, exist solely as a function of the influence of factors within the individual (endogenous), rather than as a function of external (exogenous) influence, then the relevance of cognitive theories is diminished considerably. Bowlby has, however, noted that acknowledgement of the importance of cognitive, information-processing, variables does not preclude the attribution of a significant role also, to neurophysiological processes (Bowlby, 1985: p. 261). He acknowledged that a relationship exists between abnormal levels of certain neuroendocrines, neurotransmitters and depression *(sic)*, but questioned the assumption that such a causal relationship was always uni-directional: from changes in neurophysiological processes to affective disturbance. The variation in the size and pattern of neurophysiological responses to psychological events could be accounted for, in part, by individual differences which may have a genetic base. Bowlby suggested, however, that subjection to severely stressful conditions, especially during childhood, might effect a permanent

change in the neuroendocrine system so that it becomes thereafter more or less sensitive (Bowlby, 1985:p.262).

The Concepts of Attribution and Locus of Control

The role of life events. The potential role of 'life events' in the precipitation of affective disorder underpins the theoretical models described briefly above and has been the subject of much research activity. The methodological weakness of many life events studies has been criticised by Paykel (1983), in particular the retrospective nature of life-events interviews. When questioned, many patients try to recall events which may have played a part in the onset of their affective disorder, commonly described as the "search for meaning" (Kendell, 1983b). Finlay-Jones (1981) asserted that although it was not clear how important a cause of depression (*sic*) life events were, various studies show that some quality of life events, such as degree of loss involved, were *one* of the causes of depression (*sic*). Although the literature for mania is not as clear as for depressed affect, there are indications that manic episodes may also be a form of 'maladaptive response' to life events. Ambelas (1979), for example, identified a significant life event occurring in one third of a sample of manic patients (n=69) admitted to hospital, in the month before admission. Studying the four-month period before admission, Kennedy *et al.* (1983) identified a similar life event in 85 per cent of a manic sample, representing twice that of a matched control group of orthopaedic patients. Furthermore, the manic patients rated 66 per cent of the events as "highly undesirable" compared with 30 per cent of the matched controls. Such findings do not challenge traditional biochemical

assumptions about the genetic base of manic depressive psychosis (see Angst, 1966; Bertelson, 1977 and Perris, 1966) but suggest that the patient's perception of environmental events may play a part in the genesis of both mania and depressed affect. The significance of a life-event does not rest exclusively upon the temporal relationship between environmental events and symptoms of depressed affect. As the cognitive theories illustrate, the process by which the patient perceives and evaluates such environmental events may also be significant in determining the impact of such events upon affect.

Attribution. The concept of *attribution* involves the explanation of events in terms of the causal effect of various factors. Valins and Nisbett (1972) defined it as the "process whereby the individual 'explains' his world"(p.137). As a general rule people implicate either factors within their control, such as their own behaviour, or factors outwith their control, such as the action of others, events such as the weather, their physiological state or the effect of drugs (Hewstone, 1983; Schacter & Singer, 1962). Valins and Nisbett believed that people often seek the consensus of others to assist in such explanations, except where some aspect of their behaviour is deemed to be 'bad' or 'shameful' (Sarnoff & Zimbardo 1961; Schacter 1959). Where such consensual validation is avoided, debilitating feelings of inadequacy, shame and abnormality may result.

The phenomenology of affective disorder has documented similar feelings, especially powerlessness and futility (Sackheim and Wegner, 1986). In a study of suicide attempters, 'hopelessness' was identified

as the key variable (Beck, Kovacs and Weismann, 1975). The more depressed was the patient, the more prone she was to expressions of self-blame, self-deprecation and feelings of guilt: that is, to attribute the *cause* of the depression to some personal deficit. This view was supported by Rizley's finding that depressed subjects attributed positive outcomes to external factors, and negative outcomes to internal sources (Rizley,1978), and Seligman *et al.*'s similar conclusion that:

> ...a certain attributional style combined with bad outcomes causes depression (Seligman *et al.*, 1979).

They did not rule out, however, the possibility that in affective disorder, people might attribute bad outcomes to internal, stable and global causes (Seligman *et al.*, 1979). A further sex variable distinction was proposed by Frieze (1975), who suggested that women with depressed affect tend to attribute blame to themselves when things go wrong, whereas men tend to blame others. Brewin (1986) has suggested, however, that the relationship between cognitions and depression may be more complex and that *noncausal* cognitions, such as self-evaluative judgements, may play a key role in the reduction of self-esteem.

Although Beck's original view was that a thought disorder may be common to all types of psychopathology (Beck, 1963), more recent research suggests that the thinking style of patients with depressed affect differs significantly from other patient groups. Sackheim and Wegner (1986) showed that schizophrenic patients displayed the same 'self-serving' bias as normal controls, when their attributions of control

over positive and negative events were tested. Subjects with depressed affect showed the opposite response: blaming themselves for failures and re-attributing *success* to outside factors. Their study supported Beck's formulation that a self-punitive bias characterises patients with depressed affect, in attributions of responsibility. Cook and Peterson (1986) distinguished between depressed and non-depressed female undergraduates on the endorsement of self-deprecating statements and the use of illogical justification for causal beliefs, supporting their hypothesis that depressives are *irrational (sic)*, both in their beliefs and their justification. Lewinsohn *et al.* (1980) had earlier challenged such views of the 'irrational' nature of 'depressive' thinking style by showing that, when asked to evaluate their social performance, patients with depressed affect showed greater concordance with observers than did normal controls. Sackheim (1983) has suggested that the goal of psychotherapy may not, therefore, be to encourage *accurate self-appraisal*, but may instead involve the promotion of use of the cognitive disotortions that characterise normal functioning.

Locus of control. Attempts to measure the extent to which a person perceives events as a consequence of his or her own behaviour, and therefore potentially under personal control, have been described as 'locus of control' (Lefcourt, 1977). Locus of control describes the perception of events as a function of the person's behaviour, or as a function of luck, fate, chance or some other factors beyond the persons control. To date, there has been only a limited focus upon the role of such a concept in affective disorder in general.

One of the key measures in locus of control research is Rotter's (1966) *Interal-External Scale*, which measures the extent to which people believe that they can control what happens to them (internal control) or believe that events are largely outwith their control (external). The scale measures expectation of generalised reinforcement and Rotter cited a series of studies which provided strong support for the hypothesis that people with a strong belief in their capacity to control their own destiny are likely to be more aware of the way the environment shapes their behaviour and place more value on the development of coping skills. As a result they were, in Rotter's view, more sensitive to attempts to influence them (Rotter, 1966).

Rotter's scale was taken a stage further by Reid and Ware (1974) in their development of the Three Factor Internal-External Scale. This scale attempted to identify sub-categories within the global 'internal' or 'external' locus of control measure. Three sub-divisions were identified: *Fatalism*, where an attribution to luck or chance is made; *Social Systems Control*, where an attribution to socio-political factors is made; and Self-Control, where the attribution is made to personal action. Reid and Ware (1974) argued that highly developed self-control scores could exist alongside attributions of fatalism or political powerlessness and *vice versa*. This echoes Garber *et al.*'s suggestion that "hopelessness" and "helplessness" are different (Garber *et al.*, 1980).

Several studies have examined the beliefs of patients with affective disorder, using such standardised locus of control measures.

The suggestion that 'negative expectations' might play a key role in the precipition of different kinds of maladjustment, such as anxiety or depression, is not new (*cf.* Phares, 1972). Failure to attain certain outcomes *might* produce feelings of loss, but only if the individual defines such outcomes as essential or desirable. The process by which individuals describe their capacity to control such outcomes, and thereby attain necessary goals, is represented in the locus of control hypothesis. However, such a loss need not result only in one form of emotional distress. Indeed, the complexity of affective disorder is echoed in Phares' observation that depression (*sic*) may:

> ...represent a situation where the person realises that the achievement of valued goals is blocked and that the blockage may be relatively permanent. If the blockage is seen as temporary, anger or hostility is more likely. When the element of finality is present, the reaction is more likely to be depression (Phares, 1976 p.125).

Miller and Seligman (1973) argued that depression (*sic*) results from learning that reinforcement is independent of voluntary responses. Depression, they continued:

> ...is a specific cognitive distortion of the perception of the ability of one's own responses to change the environment, rather than a general 'pessimism' (Miller and Seligman, 1973 p.82).

In effect, the depressed person views as futile, any personal attempt to change the circumstances of her life. Within this conceptual framework, highly 'externalised' individuals should be more susceptible to learned helplessness. Small, but significant, levels of support for such a relationship between externality and affective disorder were first offered by Abramowitz (1969) but were questioned by Lamont who argued that this correlation could be due to the pessimistic wording of

external items and optimistic wording of internal items on the Rotter's Internal-External scale (Lamont, 1972).

The 'learned helplessness' hypothesis, translated into locus of control terms, predicts that highly externalised individuals are unable to see themselves as capable of controlling outcomes and therefore become depressed. Such a hypothesis does not, however, preclude the possibility that affective disorder can originate from the opposite perspective. Phares (1972) has suggested that two kinds of people might suffer from affective disorder: those who possess a strong generalised expectancy that negative outcomes are their responsibility; and those who do not expect to attain valued goals or outcomes. This hypothesis supports Rotter's original speculation that a curvilinear relationship might exist between pathology and locus of control: subjects occupying either extreme presenting with maladjustment. Evidence of this curvilinear relationship can be seen in the clinically depressed population where externalised patients feel helpless to control their plight and are sad; the internalised group also feel sad but this derives from guilt or anger which stems from a perceived failure to accept responsibility, or from sheer 'incompetence'. In this sense, one group may tell themselves that they are unable, incapable and therefore hopeless, whereas the others tell themselves they should have behaved differently and therefore have failed.

Frieze's (1975) distinction between those individuals who blame themselves and those who blame others, a notable difference existing bvetween men and women, can also be restated in terms of the locus of

control hypothesis. Molinari (1979) drew a distinction between *congruent externals*, who do not expect reinforcement to be contingent upon their own behaviour; and *defensive externals* who adopt externalised beliefs as a defence against feelings of personal failure. Women, therefore, may be conceptualised as congruent externals, who accept blame for failure too readily, whereas men (defensive externals) are quick to blame others.

The highly externalised individual can also be described as fatalistic, believing that nothing can be done to relieve or recover the situation. The externalised subject who experiences negative life events may feel powerless to control or otherwise cope with them. It has been suggested that some people have high expectations for 'malevolent outcomes', and are more likely to be depressed than those with a lower malevolence expectancy (Gregory, 1981). In a similar vein, Lefcourt (1981) has reported that externals were:

> ...more likely to report distress associated with life events, and that unpleasant events had a more lingering impact on moods exhibited by externals (Lefcourt, 1981, p.269).

Despite these hypotheses, data from studies of clinical populations, as opposed to mildly depressed student samples, are uncertain and often inconclusive. In a study of a hospital sample which included 54% *psychotic depressives* (*sic*), Legget and Archer (1979) reported a significant relationship between externality and affective disorder, with the strongest correlations for male patients. These results require cautious consideration, however, in view of the range of diagnoses present in the sample (including alcoholism and schizophrenia

as well as affective disorder), epecially amongst the male subjects. Moore and Paollilo (1984) found only a *mild* relationship between externality and affective disorder and Peterson *et al.* (1978) found no relationship at all. The apparent discrepancy between these findings can be accounted for, in part, by the differences in the samples. Legget and Archer's sample was of mixed sex and mixed diagnoses, with more than half the sample presenting with a psychotic form of affective disorder. Moore and Paolillo's sample was non-psychotic and in the Peterson *et al.* study no less than 18 different diagnoses were reported in a sample of 39 patients.

More recently, it has been hypothesised that dysfunctional beliefs, in particular attributional biases, either result from long-term depressions (*sic*), or lead to greater time spent in depressive episodes (Eaves and Rush, 1984). These authors further concede that self-blame may be a relatively stable and enduring characteristic of those predisposed to affective disorder. Rush, Weissenburger and Eaves (1986) also suggested that dysfunctional attitudes, presenting during remission, may represent a potential vulnerability factor *or* a sensitive indicator of persistent depressive psychopathology. In a more specific examination of 'self-blame', Brewin (1986) argued that self-esteem deficits, occurring in depression (*sic*), may be associated with a perceived discrepancy between internal standards and actual performance, an hypothesis with a bearing on both locus of control and attributional theory. The clinical importance of Rush *et al.*'s and Brewin's hypotheses is that they both reflect interest in the use of 'unconditional shoulds and musts', first described by Ellis (1962).

Conclusion

In this chapter, three discrete 'cognitive' model of affective disorder were reviewed briefly and two discrete cognitive processes (attribution and locus of control) were discussed in general and in relation to affective disorder, in particular. The coverage of cognitive 'models' and cognitive 'processes' in this chapter was selective. The coverage here represents the author's view of theoretical issues which are relevant to the consideration of the care and treatment of manic depressive psychosis, which forms the core of the main study in Part Three of the thesis. This review was not intended in any way to be comprehensive. This theoretical overview represents no more than the minimum introduction necessary for the consideration of the sub-studies which comprise the remaining chapters in Part Two of the thesis.

Although interest in the individual's interpretation of experience, and the relationship of such 'thinking' to emotional problems, can be traced back as far as the Stoic philosophers, a renaisance of interest in the functional relationship between cognition and emotion in psychiatry has been evident over the past three decades. The three cognitive models reviewed describe the relationship between environmental events and 'subsequent' affective disorder, by reference to specific information-processing constructs. The three models reviewed represent *sociological* (Brown and Harris, 1978), *psychological* (Abramson *et al.*, 1978) and *psychiatric* (Beck *et al.*, 1980) interpretations of the role of cognition in affective disorder.

In the final section of this chapter consideration was given to the role of discrete cognitive processes, focussing upon attribution and locus of control. These represent specific 'interpretations' of environmental events: *attribution* representing the individual's interpretation of the meaning of events which have occurred in the past, and their relationship to the individual and her own behaviour; *locus of control* representing the individual's expectations regarding her capacity to influence future events.

CHAPTER 10

LOCUS OF CONTROL IN MANIC-DEPRESSIVE PSYCHOSIS: SUB-STUDY 5

In Chapter 9, contemporary interest in psychosocial models of affective disorder was illustrated by reference to three 'cognitive' models. These models, which emphasised the role of the mediational processes of cognition and attribution, were selected for review for two reasons. First, in view of assertions made about the interpersonal and psychosocial role of the psychiatric nurse, it is appropriate to focus attention on conceptual models which deal specifically with such processes. Second, the three models reviewed represent 'ideologies' of affective disorder based upon empirical evidence, representing a clinical research basis for psychosocial model-making in affective disorder. Although the models reviewed have not been used as the basis for model-making in manic depressive psychosis *per se*, many of the hypotheses regarding the role of information-processing could form the basis of a hypothetical model of manic depressive psychosis and are amenable to experimental manipulation.

Sub-Study 5 : A Descriptive Study of Patients Diagnosed as Suffering From Manic Depressive Psychosis When In Remission.

Despite the extensive literature on more severe forms of affective disorder (see Arieti and Bemporad [1980] for review), the psychological functioning of patients diagnosed as suffering from manic depressive psychosis has received limited attention. This may be due

partly to the conviction that such disorders arise from biophysical origins (*cf.* Angst, 1966; Perris, 1966; and Bertelson *et al.*, 1977). As discussed in Chapter One, the apparent existence of two 'forms' of affective disorder - mild and severe, or 'neurotic' and 'psychotic'- has led to the assumption that less severe forms of affective disorder represent a *psychological* problem, whereas severe affective disorder arises from an organic base, as yet unspecified. Some researchers have even asserted that 'endogenomorphic' affective disorder is due to impairment of selected brain mechanisms and that such patients are less likely to have characteriological predispositions towards 'depression' (cf. Klein, 1974). This view, which is the contemporary reflection of Kraepelin's original hypothesis, suggests that severe forms of affective disorder, such as manic depressive psychosis, might occur solely as a function of biophysical variables, independent of any psychosocial influence. Support for the view that specific cognitive processes, such as attribution, are not of causal significance in more severe forms of affective disorders, has been reported recently. A study by Zimmerman, Coryell & Corenthal (1984) found no significant association between attribution style (tested by Seligman *et al.*'s Attribution Style Questionnaire [1979]) and 'endogneous depressive' subtype (tested by the Dexamethasone test). The study, however, reported only upon patients in their first week of hospitalisation; many patients failed to complete the questionnaire and the sample size was small, leading the authors to conclude that the mean difference between groups was small compared to within group variation. It has been suggested further that patients with severe affective disorder only show a 'depressive attributional style' once their profound

depression begins to lift (Hamilton and Abramson, 1983). Such studies suggest that, where present, psychological factors might follow, rather than precipitate, or co-exist with, symptoms of affective disorder.

Aim of sub-study 5

The sub-study aimed to investigate a specific aspect of the psychological functioning of women diagnosed as suffering from manic depressive psychosis: namely, their responses to standardised locus of control scales. Despite the relative popularity of locus of control measures in the construction of conceptual models of psychological functioning (see Lefcourt, 1977; 1981, and Phares, 1972), few studies have reported on the use of such measures in severe affective disorder (Lefcourt, 1981). As noted in Chapter 1, women occupy a special position in the epidemiology of affective disorder in general. In view of the potential for differences between male and female subjects, only women were included in sub-study 5. In the review of the cognitive theories presented in Chapter 9, it was noted that some patients appear to display a 'depressive thinking style' as a *consequence* of the acute 'depressive' episode (*cf.* Hamilton and Abramson, 1983). In view of the apparent potential for the recurrence of acute episodes of affective disorder, which exists in manic depressive psychosis, the sub-study focussed upon patients carrying this diagnosis, when they were 'affectively well': that is, when they were *relatively symptom-free*. It was hoped that by studying patients with manic depressive psychosis (in remission) possible similarities and/or differences, between these subjects and samples of the normal population, might be demonstrated. Apart from providing data on the functioning of manic depressive

patients when relatively 'symptom-free', such data might also be used to clarify the possible role played by specific psychological processes in the stimulation of acute episodes of the disorder.

The hypotheses

Extrapolating from the general locus of control literature and the available studies which have examined the construct in relation to affective disorder, the sub-study proposed the following six hypotheses, which are presented here in *a) null and b) research (directional) form:*

1a. Patients with a diagnosis of manic depressive psychosis, who have a history of mania and depression and who are not showing overt symptoms of the disorder, will not differ significantly from normal subjects on a generalised locus of control scale (Null hypothesis).

1b. Subjects with a diagnosis of manic depressive psychosis, who have a history of mania and depression and who are not showing overt symptoms of the disorder, will show lower scores (that is, will be more internalised) than normal subjects on a generalised locus of control scale (Research hypothesis).

2a. Subjects with a diagnosis of manic depressive psychosis, who have a history of depression-only and who are not showing overt symptoms of the disorder, will not differ significantly from normal subjects on a generalised locus of control scale (Null hypothesis).

2b. Subjects with a diagnosis of manic depressive psychosis, who have a history of depression-only and who are not showing overt symptoms of the disorder, will show higher scores (that is, will be more externalised) than normal subjects on a generalised locus of control scale (Research hypothesis).

3a. Subjects with a diagnosis of manic depressive psychosis, who have a history of both mania *and* depression and who are not showing overt symptoms of the disorder, will not differ significantly from subjects with a diagnosis of manic depressive psychosis who have a history of depression-only, who are not showing overt symptoms of the disorder, on a generalised locus of control scale (Null hypothesis).

3b. Subjects with a diagnosis of manic depressive psychosis, who have a history of both mania and depression and who are not showing overt symptoms of the disorder, will show lower scores (that is, will be more internalised) than subjects with a diagnosis of manic depressive psychosis, who have a history of depression-only, who are not showing overt symptoms of the disorder, on a generalised locus of control scale (Research hypothesis).

4a. Subjects with a diagnosis of manic depressive psychosis, who have a history of mania and depression and who are not showing overt symptoms of the disorder, will not differ from normal subjects on a locus of control scale which defines discrete locus of control factors (Null hypothesis).

4b. Subjects with a diagnosis of manic depressive psychosis, who have a history of mania and depression and who are not showing overt symptoms of the disorder, will show lower scores (that is, will be more internalised) than normal subjects on a locus of control scale which defines discrete locus of control factors (Research hypothesis).

5a. Subjects with a diagnosis of manic depressive psychosis, who have a history of depression-only and who are not showing overt symptoms of the disorder, will not differ significantly from normal subjects on a locus of control scale which defines discrete locus of control factors (Null hypothesis).

5b. Subjects with a diagnosis of manic depressive psychosis, who have a history of depression-only and who are not showing overt symptoms of the disorder, will show higher scores (that is, will be more externalised) than normal subjects on a locus of control scale which defines discrete locus of control factors (Research hypothesis).

6a. Subjects with a diagnosis of manic depressive psychosis, who have a history of mania and depression and who are not showing overt symptoms of the disorder, will not differ significantly from patients with a diagnosis of manic depressive psychosis, who have a history of depression-only and who are not showing overt symptoms of the disorder, on a locus of control scale which defines discrete locus of control factors (Null hypothesis).

6b. Subjects with a diagnosis of manic depressive psychosis, who have a history of mania and depression and who are not showing overt symptoms of the disorder, will show lower scores (that is, will be more internalised) than subjects with a diagnosis of manic depressive psychosis, who have a history of depression-only and who are not showing overt symptoms of the disorder, on a locus of control scale which defines discrete locus of control factors (Research hypothesis).

The Method

A sample was drawn from a pool of female patients, diagnosed as suffering from manic depressive psychosis, who attended a Lithium Clinic at a Psychiatric Out-Patients Department of a District General Hospital. The sample was drawn from all female patients who carried a diagnosis of manic depressive psychosis who, in the view of the medical staff, were not showing overt signs of mania, hypomania or depression at the time of the drawing of the sample. All subjects attending the Clinic were resident in their own home at the time the sample was drawn. The sample subjects were asked to complete two standardised measures of locus of control: a form of Rotter's (1966) Internal-External Scale and a form of Reid and Ware's (1974) Three Factor Internal-External Scale. Group scores on each scale were compared with reported norms and a comparison was made between subjects with a history of mania and depression, and subjects with a history of depression-only. The null hypotheses predicted that the clinical sample would not differ significantly from the normative groups on the two scales and that no significant difference would exist between subjects

with a history of mania *and* depression and subjects with a history of depression-only.

The *Subjects.*

The sample (n=75) was drawn, using random number tables, from a pool of approximately 145 female patients who carried a discrete diagnosis of manic depressive psychosis and who attended the Lithium Clinic of a District General Hospital.[1] Forty-four patients agreed to participate in the sub-study (58.7%). The mean age of the patients with a history of depression and mania (n=26) was 50.7 years (range 29 - 67); and for the depression-only group (n=18) 53.2 years (range 32 - 75). The mental state of the subjects was not assessed by the author. All subjects were seen at the clinic at intervals of between one and three months by a psychiatrist. None of the participating subjects was regarded by the psychiatrist as clinically manic or depressed at their last appointment.

Materials and procedure

Two locus of control scales were employed in the sub-study. The first scale represented a measure of generalised expectancies of reinforcement and was one of the most widely-used locus of control scale in research studies (Lefcourt, 1981). The second scale identified discrete locus of control factors which, in the author's view, were considered to be of potential relevance to the precipitation of

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[1] This sub-study was approved by the Research Sub-Committee of the Health Board within whose area of jurisdiction the study was conducted.

affective disorder in general. The scales employed in the sub-study were:

1. The Internal-External Locus of Control Scale (Rotter 1966), entitled the *Social Reaction Inventory* (SRI) [See Appendix 9];

2. The Reid-Ware Three Factor Internal-External Scale (Reid and Ware 1974), entitled the *Belief Survey* (BS) [See Appendix 10].

The scale titles (SRI and BS) were drawn from Lefcourt (1976). The SRI comprised 23 forced choice items with six fillers. The scale provided a single score, maximum 23. The BS comprised 32 forced choice items with 13 fillers. The scale provided three factor scores: *Fatalism* (maximum 12); *Social Systems Control* (maximum 12) and *Self-control* (maximum 12).

Each subject received a written invitation to participate in the sub-study which was described in very general terms as "attempting to examine the care of women suffering from depressive illness". The letter noted that the subject's name had been supplied by the psychiatrist responsible for supervising her treatment at the Lithium Clinic. The letter provided a brief outline of the aim of the study and the procedure for completion of the two scales, which were enclosed. Subjects were asked to complete and return the two scales, if they were agreeable. The scales were coded to distinguish depression-only subjects from those with a history of mania and depression. The patients were ,however, asked specifically *not* to identify themselves,

thereby making their participation anonymous. A stamped-addressed envelope was provided and all subjects were thanked in anticipation of their co-operation.

Normative comparison groups

Four of the hypotheses comprising the sub-study required the comparison of the sample subjects, who had been diagnosed as suffering from a manic depressive psychosis, with normal subjects. Two normative samples of female subjects, which had previously been reported, were used as comparison groups on the two locus of control scales. Although a review of the literature shows conflicting findings, there are reasons for assuming that the sex of the subject might influence scoring on either of the locus of control scale. Rotter (1966) noted that other studies (Crowne and Conn, 1965; Ware, 1964) indicated that sex differences, on his I-E scale, appeared to be minimal. However, Gore and Rotter's (1963) study of male (n=134) and female (n=169) university students, showed a significant difference between males and females. These conflicting findings may be a function of the sample sizes, Gore and Rotter's study involving considerably larger samples than Crowne and Conn's or Ware's studies. In Phares (1972) view, although some studies report sex differences, whereas others do not, "sex often moderates the relationship between I-E scores and other behaviours (p.45)," suggesting that internality often is related to achievement behaviour in males, but not in females.

Although significant 'cultural' differences have been reported, between North American and Chinese school students (Hseih, Shybutt and Lotsof,

1969), and between black and white North American samples (Shaw and Uhl, 1971; Strickland, 1972), Parsons, Schnieder and Hansen (1970) found no significant difference between Danish and North American students, despite their assumption that the two societies differed widely in terms of governmental control. There are indications, however, that subjects from lower socioeconomic groups are more externalised than more middle-class subjects (Gruen and Ottinger, 1969).

The two normative samples selected were as follows:

Rotter's Internal-External Scale. Hamsher, Geller and Rotter (1968) reported norms for a sample of 113 female introductory psychology class, university students. The subjects were required to complete the scale during class time as part of a wider study which examined relationships between interpersonal trust scores, locus of control and the students' view of the Report of the Warren Commission. The authors reported that the mean and standard deviation was consistent with those obtained in previous studies.

Reid and Ware's Three Factor Internal-External Scale. Lefcourt (1977) reported norms on 44 female university students undertaking an Introductory Social Psychology course. No details of the administration of the scale were provided.

Results

The Social Reaction Inventory (SRI). Copies of the SRI were sent to all 44 subjects: 36 scales were returned completed. Of the remainder, five were incomplete and three incorrectly scored. The completed scales were divided into two groups: subjects with a history of depression-only, and subjects with a history of depression and mania. The scores of these two groups are summarised in Table 10:1. The subjects' scores were compared with a female normative sample (n=133) drawn from a university student population, reported by Hamsher, Geller and Rotter (1968).

Table 10:1: SRI Scores: Depression-only and mania/depression subjects

	n	$\bar{X}$	SD	Range	Normative Sample *	
					$\bar{X}$	SD
Dep.-only	18	13.83	2.14	10-18	11.0	3.96
Mania + Dep.	18	9.5	2.50	4-13		

* Hamsher, Geller and Rotter (1968)

Hypothesis 1 : Patients with a diagnosis of manic depressive psychosis, who have a history of mania and depression and who are not showing overt symptoms of the disorder, will not differ significantly from normal subjects on a generalised locus of control scale.

The sample data were analysed using a zM test. The sample subjects with a history of mania and depression (n=18) showed a lower mean score than the normative controls, on the SRI, with a less variable distribution of scores about the mean. However, comparison between the normative

sample and the depression and mania group showed no significant difference between the two groups ($z = 1.6$, $p < 0.10$, n.s.).

Hypothesis 2 : Patients with a diagnosis of manic depressive psychosis, who have a history of depression-only and who are not showing overt symptoms of the disorder, will not differ significantly from normal subjects on a generalised locus of control scale.

The sample data from the subjects with a history of depression-only (n=18) were analysed using a zM test. These subjects showed a higher mean score than the normative controls on the SRI, with a less variable distribution of scores about the mean. Comparison between the normative sample and the depressed-only subjects showed a significant difference at the 0.2 per cent level ($z = 3.03$, $p < 0.0024$).

Hypothesis 3 : Patients with a diagnosis of manic depressive psychosis, who have a history of both mania and depression and who are not showing overt symptoms of the disorder, will not differ significantly from patients with a diagnosis of manic depressive psychosis who have a history of depression-only, who are not showing overt symptoms of the disorder, on a generalised locus of control scale.

The two groups comprising the sample were compared using two-tailed independent samples t-test. The mania and depression subjects showed a significantly lower mean score than the depression-only subjects ($t = 7.24$, d.f. $=34$, $p < 0.001$).

The Belief Survey (BS). Copies of the BS were sent to all 44 subjects in the sample, of whom 38 returned completed scales. Four subjects returned the scale incompletely scored and two subjects failed to return the scale. The scores, distinguishing between subjects with a history of depression-only and subjects with a history of depression and mania, are summarised in Table 10.2. The subjects' scores were compared with a female normative sample (n=44) drawn from a university student population, Reid and Ware (1973) cited by Lefcourt (1976).

Hypothesis 4 : Patients with a diagnosis of manic depressive psychosis, who have a history of mania and depression and who are not showing overt symptoms of the disorder, will not differ signficantly from normal subjects on a locus of control scale which defines discrete locus of control factors.

Data from the depression and mania group were compared with the normative sample using a zM Test. This group showed a significantly *lower* (more internalised) mean score than the normative sample, on the *Social Systems Control factor* ($z = 4.65$, $p < 0.0001$). The group's mean score on the *Fatalism* factor was not significantly different from the normative sample on the *Fatalism* factor ($z = 0.78$, n.s.). On the *Self-Control* factor, however, this group's scores were significantly *higher* (more externalised) than the normative sample ($z = 2.72$. $p < 0.007$).

Hypothesis 5 : Patients with a diagnosis of manic depressive psychosis, who have a history of depression-only and who are not showing overt symptoms of the disorder, will not differ significantly from normal

subjects on a locus of control scale which defines discrete locus of control factors.

Table 10:2 : BS Scores : Depression-only and mania/depression subjects

	n	$\bar{X}$	SD	Range	Normative Sample*	
Depression-only	13				$\bar{X}$	SD
Fatalism Score		6.08	2.53	1-10	4.47	2.88
Social Systems Control Score		6.69	2.06	4-11	6.84	2.75
Self-control Score		4.77	2.98	0-9	5.52	1.91
Mania/depression	25					
Fatalism Score		4.92	2.66	0-10		
Social Systems Control Score		4.28	2.57	0-8		
Self-control Score		6.56	2.87	1-11		

* Reid and Ware (1973)

The data from the depression-only subjects were compared with the normative sample, using a zM Test. The depression-only subjects differed significantly from the normative sample on the *Fatalism* factor ($z = 2.01$, $p < 0.04$). However, no significant difference was found on the *Social Systems Control* factor ($z = 0.196$. n.s.), or on the *Self-Control factor* ($z = 1.41$, n.s.).

Hypothesis 6 : Patients with a diagnosis of manic depressive psychosis, who have a history of mania and depression and who are not showing overt symptoms of the disorder, will not differ significantly from

patients with a diagnosis of manic depressive psychosis, who have a history of depression-only and who are not showing overt symptoms of the disorder.

The two groups comprising the sample were compared using a two-tailed two-tailed independent-samples *t* test. The depression-only group showed significantly higher (more externalised) scores on the *Fatalism* ($t = 4.1$. $d.f = 36$, $p < 0.001$) and *Social Systems Control* factors ($t = 9.269$, $d.f. = 36$. $p < 0.001$). On the third factor, *Self-Control* the mania and depression group showed significantly higher (more externalised) scores than the depression-only subjects ($t=5.7$, $d.f.=36$, $p<.001$).

Discussion

The first three hypotheses involved analyses of the sample's scores on the *Social Reaction Inventory* (SRI). The (SRI) is an equivalent of Rotter's original I-E scale (Rotter, 1966), measuring *generalised* expectancies of reinforcement. Although the mania and depression group showed a lower (more internalised) mean than the normative sample on the *SRI*, this was not statistically significant. On this scale, the mania and depression group scored within normal limits. Therefore, null hypothesis 1, which predicted that there would be no difference between the mania and depression group and the normative sample, was not rejected.

The depression-only group mean was significantly higher (more externalised) than that of the normative sample, on the SRI. Although

the depression-only group's scores, which ranged from 10 - 18, were far below the maximum possible score of 23, their scores on the *Social Reaction Inventory* (SRI) showed a significantly more externalised presentation, compared with the the normative sample. Therefore, null hypothesis 2, which predicted that there would be no difference between the depression-only subjects and the normative sample, was rejected. When the two groups comprising the sample were compared on the SRI the mania and depression group showed a significantly lower (more internalised) score when compared with the depression-only subjects. this was supported strongly, Therefore, null hypothesis 3, which predicted that no difference would exist between the two groups comprising the sample on the SRI, was rejected.

In the sub-study reported here, subjects with a diagnosis of manic depressive psychosis, who have a history of mania and depression, and who could be described as *in remission* (that is, not showing overt signs of the disorder) scored within 'normal limits' on the scale. Alternatively, the second group drawn from the sample, manic-depressive subjects with a history of depression-only, showed significantly more externalised scores, which were outwith normal limits, suggesting that this group were projecting the kind of 'vulnerability' described by Rotter (1966), even when they were 'affectively well', or symptom-free.

The other three hypotheses involved an analysis of the sample's scores on the *Belief Survey* (BS). The BS is an equivalent of Reid and Ware's (1974) Three-Factor Internal-External Scale. This measured the specific role of *Fatalism*, *Social Systems Control* and *Self-Control*, in the subject's expectancies of reinforcement. Null hypothesis 4 predicted

that no difference would exist between the mania and depression group and the normative sample, on all three factors. The group mean on the *Fatalism* factor was higher (more externalised) than that of the normative sample, although this difference was not significant. On this factor, therefore, the null hypothesis was not rejected. The group's scores on the *Social Systems Control* factor was significantly lower (more internalised) than that of the normative sample. The null hypothesis was, therefore, rejected. This difference was also in the direction predicted by the research hypothesis. However, the group's scores on the *Self-Control* factor were significantly higher (more externalised) than the scores of the normative sample. Consequently, the null hypothesis was rejected. However, this finding was in the opposite direction of the research hypothesis, which predicted lower than normal scores for the mania and depression group.

The depression-only group showed significantly higher (more externalised) scores on the *Fatalism* factor, but did not differ significantly from the normative sample on the *Social Systems Control* or *Self-Control* factors. Consequently, the null hypothesis was rejected in the case of the *Fatalism* and not rejected for *Social Systems Control* and *Self-Control*.

The BS scores from both groups comprising the sample were compared to test the final hypothesis. The depression-only group showed significantly higher (more externalised) scores on the Fatalism and *Social Systems Control* factors. These findings were in the direction predicted by the research hypothesis. The mania and depression group

showed significantly higher scores on the *Self-Control* factor, and the null hypothesis was rejected. However, this finding was in direct opposition to the research hypothesis, which had predicted that the mania and depression group would show *lower* (more internalised) scores than the depression-only subjects.

These results suggest that a specific psychological vulnerability, in the form of externalised locus of control, might be present in patients diagnosed as suffering from manic depressive psychosis in remission. Even when 'affectively well' (that is, in the absence of any overt symptoms of the disorder) significant differences existed between the clinical sample and the normative sample. However, the differences found were not all in the direction predicted by the research hypotheses. The depression-only group were significantly more 'externalised' than the normative sample on the *Social Reaction Inventory*, which was a generalised measure of locus of control. This suggested that these subjects might be more 'fatalistic' regarding their capacity to influence the outcome of events. However, the mania and depression group scored within normal limits and did not appear to project the 'fatalistic vulnerability' described by Rotter (1966).

The *Belief Survey* looked at the subject's perception of the influence of 'social systems' and their own 'self-control', as well as 'fate', in determining the outcome of events. The analysis of these scores showed that the subjects with a history of depression-only were more 'fatalistic' than the normative sample, as might be expected from the review of 'learned helplessness' theory presented in Chapter 9. This

offers further support for the concept that depression involves some form of helplessness. However, this group's perception of social systems and self control did not differ significantly from that of the normal subjects. Although the difference was not statistically significant, the depression-only group showed a lower (more internalised) mean score than the mania and depression group on the self-control factor. This may be attributed to subjects experiencing severe guilt, or engaging in 'self-blame', thereby increasing their 'internal' score. Alternatively, the mania and depression group did not differ from the normal subjects on the *Fatalism* factor and were more internalised on the *Social Systems Control* factor. This latter finding appears to be consonant with the traditional view of manic and hypomanic patients, that they display a heightened sense of control, in their relationships with other people. The most interesting finding was that this group showed a significant 'deficiency' in terms of *self-control*. Although the research hypothesis predicted that these subjects, with their history of manic episodes, perhaps accompanied by degrees of concurrent grandiosity, would show an unrealistically heightened sense of 'self-control'. Not only was this not confirmed, but the opposite was shown to be the case, with this group showing an abnormally externalised score on this factor.

Care needs to be taken over generalising from these findings. Although selected carefully, the samples were small, especially the size of the depression-only group in the *Belief Survey* analysis. Just over one-half of the patients accepted the invitation to participate in the sub-study. In the case of the depression only group it could be argued that

those patients who agreed to participate were the most passive, or 'helpless' individuals, and that the mania and depression subjects who responded represented those who were most 'affectively well' and who subsequently compared favourably with the normative sample. This hypothesis does not, however, explain the externalised *Self-Control* scores shown by this group. Also, although the normative sample used as a comparison in the SRI (Rotter's I-E Scale) study was large, it comprised female university students who, it can safely be assumed, were younger than both patient samples, on average. Although there are no reported comparisons for age, Harvey's (1971) study of administrators and Palmer's (1971) study of male veterans, showed significantly lower (more internalised) scores on the SRI in older subjects. This would suggest that a normative sample of older women would have also have shown more internalised scores than the undergrduate sample. Consequently, although the normative sample were not age-appropriate, there are grounds for assuming that an older female sample would have served only to reinforce the difference between the clinical and normative samples.

Similarly, the normative sample used in the Belief Survey analysis was small, and comprised female undegraduates, who might well have differed from the patients samples in terms of age, education and social class. However, as noted ealier in this chapter, the role of such variables in locus of control measures is unclear. Finally, a reservation should be expressed at the use of what is, essentially, a cross-cultural comparison. However, at the time of the study British normative data on these measures was not available.

Although these data provide an insight into the psychological functioning of patients who are 'affectively well', it cannot be assumed that these differences will be present during an acute phase of illness. The study may offer support for the hypothesis noted earlier that depressive thinking style may not be in evidence until the patient's affect becomes more elevated (Hamilton and Abramson, 1983). At a level of maximum speculation these data suggest that different kinds of vulnerability exist within the depressed and manic and depressed populations. Patients experiencing only depression may have a fatalistic relationship with their 'external' world, whereas mania and depression patients, with their apparent low level of self control, may feel powerless to control their own behaviour.

CHAPTER 11

DEVELOPMENT OF THE DEPRESSION LOCUS OF CONTROL SCALE: SUB-STUDY 6

According to social learning theory, it is assumed that increasing an individual's experience in any given situation will encourage the development of specific 'expectancies' (Rotter, 1954). Expectancies, which are specific to the situation, play a greater part in determining the person's future behaviour in that situation than more generalised expectancies (Wallston *et al.*, 1976). It has also been noted that the value of a generalised measure of locus of control, such as the Rotter's I-E Scale, may have limited predictive value in a specific area of behaviour (Wallston & Wallston, 1973). Although the data presented in Chapter 10 suggest that certain attitudinal characteristics may pertain to subjects described as suffering from manic depressive psychosis, the scales employed do not measure the subject's attitude towards illness. It is conceivable that subjects might expect to control some situations in their lives, but not others. Although the Reid-Ware scale isolates fatalism as a construct which might play a significant role in generating a passive role in the face of adverse circumstances, the scale does not measure the subject's predicted response to an adverse event, such as a severe depressive illness.

Development of the Instrument

No specific scale, developed to measure locus of control in affective disorders, or indeed in relation to any other psychiatric disorder,

could be found in the literature. Psychiatric research involving the locus of control construct tends to use one of the available generalised measures, such as Rotter's (1966) I-E Scale. In the collection of the data using the Rotter and Reid-Ware scales described in Chapter 10, some subjects protested at the "silly" or "irrelevant" nature of some questions, whereas others complained of the length of the questionnaires. These casual observations lent support to the need for an instrument which was specific, rather than generalised, and which might be designed to avoid taxing the concentration of a patients with affective disorder.

Procedure

An item pool (n=33) was developed from the analysis of structured interviews, undertaken by the author and three nurse colleagues, with women who were diagnosed as suffering from manic depressive psychosis and who attended a general hospital Lithium Clinic. Each subject was interviewed by two nurses, one of whom used a 20-question format, developed by the author (see Appendix 11). The first few minutes of the interview were devoted to general questions about how the subject was feeling, after which attention was focussed upon identifying the subject's thoughts and beliefs about her illness and its possible precipitants.

From these interviews, a pool of 18 common themes was established. The item pool was reviewed by a panel of 17 psychiatric nurses who, in the author's opinion, had an extensive experience of caring for depressed patients. The panel was invited to rate each item for its

"appropriateness as an attitudinal statement concerning depressive illness", using a 0 - 4 scale (0 = not at all appropriate; 4 = very appropriate). It was decided to eliminate from consideration any item which did not gain an average rating of at least 3 on the scale. Six items failed to reach this criterion and were dropped from the item pool. The resultant 12 items were presented in the form of a six-point rating scale. In an effort to improve upon the content validity of the scale, items were worded to approximate the *Health Locus of Control Scale* (Wallston *et al.*, 1976) which had been validated as an area-specific measure of expectancies of reinforcement in relation to health-related behaviour in general.

Internal-consistency

An item-analysis was conducted using a sample of 45 women diagnosed as suffering from manic depressive psychosis, drawn from a pre-discharge hospital population and from out-patients attending a psychiatric clinic. Two items which showed negative correlations with the total score were dropped from the scale. Table 11.1 presents the final scale with item correlations with total score, *with that item removed*, based upon a sample of 45 female subjects. Each item deals exclusively with the subjects belief about the nature of her depressive illness and her personal relationship with it. Subjects were asked to rate their agreement or disagreement with each statement using the following scale, which was scored either 1-6 or 6-1 depending upon the direction of the item.

I agree strongly
I agree a lot
I tend to agree
I tend to disagree
I disagree a lot
I disagree strongly

*Table 11.1 : The DLCS** with Correlations Of Each Item with Total Score, Excluding that Item (n=45)

Item	Pearson's r
1. If I'm going to become depressed I'll become depressed, no matter what I do.	+0.239
2. To a great extent depression results from the mistakes people make in their lives.	+0.238
3. Most people don't realise how my depression just happens to people.	+0.085
4. To get over my depression I can only do what the doctor tells me.	+0.320
5. I can prevent myself becoming depressed by taking care of myself.	+0.103
6. You never know when or how this depression is going to affect you.	+0.253
7. When I get depressed it is because I have not been taking care of myself.	+0.420
8. Good mental health is largely a matter of good fortune.	+0.271
9. When I get depressed its because of something I've done or not done.	+0.202
10. People who never become depressed like me are just plain lucky.	+0.397

* *The Depression Locus of Control Scale*

Items 2,5,7 and 9 were scored as internalised statements, 1-6 (Agree strongly = 1; disagree strongly = 6) and items 1,3,4,6,8 and 10 scored

as *externalised* statements, 6-1 (agree strongly = 6; disagree strongly =1). The maximum and minimum possible scores were 60 and 10.

Reliability

Split-half reliability for the scale was tested using a sample of hospitalised patients with manic depressive psychosis and a further sample from the Lithium Clinic population (n=63). Using the Spearman-Brown prophecy formula, r=.72.

Because of the difficulty in obtaining subjects, test-retest reliability was computed on a small in-patient sample of 28 patients over a three-week period. All subjects were involved in drug-trials, but were not in receipt of any specific psychological intervention which might have influenced their scale scores over this period. The attained level of reliability was satisfactory (r=.78).

Validity

Concurrent validity was tested by comparison of DLCS and SRI scores drawn from a random sample of patients from the hospital and clinic population described above (n=49). In view of the assumed contrast between the specificity of the DLCS and the generalised nature of the Rotter scale, a high correlation between the two scales was not expected. Each subject completed the DLCS and Rotter's SRI independently, but under the supervision of a nurse. The correlation between the two scales was .61.

Scale Sensitivity

The contrasts evident between the depression-only and mania and depression subjects reported in Chapter 10 confirmed some of the assumptions regarding differences between the two populations. Such distinctions were reported, however, only for *generalised* expectancies of control. The DLCS purported to measure the patient's expectations of control over her illness and was expected, therefore, to represent a more specific measure of locus of control. In order to test the sensitivity of the instrument, a comparison was made between samples of patients with a history of depression-only, and of patients with a history of depression and mania. The null hypothesis was that no difference would exist between these subjects on their expectations of control over their depressive illness.

Two, 25-subject, samples were drawn at random from the pool of patients attending the Lithium clinic and patients being prepared for discharge at an in-patient facility, who were relatively 'symptom-free'. 45 patients agreed to participate (90%). Subjects were invited to complete the scale as part of a larger nursing research project which was examining the care of women with depression. The scores of the 45 patients who responded are summarised in Table 11.2

Table 11.2: Comparison of DLCS Scores for Depression-only and Mania and Depression Subjects

Sample	n	$\bar{X}$	SD	Range
Depression-only	24	44.42	5.47	37-53
Mania/depression	21	40.24	5.22	31-53

The minimum and maximum scores possible were 10 and 60. Moderate to high scores were recorded by the depression-only sample, and at least one subject from each group attained similarly externalised scores. Very low, that is highly internalised, scores were not, however, shown by the mania and depression group. Analysis of the data by an independent-samples two-tailed t test showed a significant difference between the two groups ($t=-2.61082$, $d.f.= 43$, $p < 0.012$). The null hypothesis, which predicted that no difference would exist between the scores of the two groups, was rejected.

Discussion

The items comprising the DLCS were drawn from structured interviews with women diagnosed as suffering from manic depressive psychosis. The content validity of the scale was further assessed by a panel of psychiatric nurses involved in the care of depressed patients.
Given that all the subjects had previously experienced at least one episode of depression, the items in the DLCS appeared to measure the subject's expectations about factors likely to promote or discourage a recurrence of depression. With the possible exception of item 2, which appeared to invite the subject to 'attribute' an explanation of depresssion in terms of the occurrence of personal events, all other items focussed upon the subject's expectations about possible future events.

The data presented suggests that, given the brevity of the scale, the DLCS is a reliable instrument. The degree of correlation with the

Rotter's Internal-External Scale suggests that it may offer a more specific measure of locus of control in depressive disorder than the more generalised format. Casual observation of subjects participating in Sub-Study 5, reported in Chapter 10, suggested the need for a shorter scale, related more directly to depressive disorder. Subjects in the sub-study reported here were able to complete the scale independently, at one sitting. In the studies reported in Chapter 10, several completed scales were ruled unacceptable due to errors and ommissions, a problem which did not occur with the shorter, DLCS scale.

By reversing the direction of the scaling of the items at random the scale carried no obvious bias. The scale purported to measure the extent to which subjects believed their depressive illness was 'within' or 'outwith' their control. In this sense the scale combined consideration of the 'fatalism' and 'self-control' factors contained in the *Belief Survey*, reported in Chapter 10. The reported difference between depression-only and mania and depression suggests that the scale may be sensitive enough to discriminate between these two sub-populations of manic depressive psychosis.

The scale can be criticised, however, on several counts. A six-point scale was selected to offer subjects greater freedom in rating their attitude, either positively or negatively, towards individual items. However, the omission of a neutral mid-point, as can be found in a typical Likert scale, meant that subjects could not express uncertainty or, more importantly, a variable attitude (sometimes 'yes', sometimes 'no'). This omission can be justified on the grounds that

indecisiveness is typical of many affective disorders. The omission of a variable mid-point made the scale a variant of the forced choice ('yes' or 'no') questionnaire, which may be easier for use with severely depressed subjects.

As noted earlier, item 2 is a highly generalised locus of control - statement, which might be interpreted as inviting an explanation of past depressive episodes. In this sense, it may be more of an *attributive* statement. Items 5 and 7 dealt with very similar ideas, the role of 'self-care' in fending off depression. Although the scale is described as dealing with future events, item 5 deals specifically with the possible preventitive role of self-care whereas item 7 appears to deal more with a review of present, or possibly past, depressive episodes. This item may, therefore, also be more of an attributive statement, than a prediction of expectancy. Although the sample drawn for the sub-study was described as 'affectively well', or relatively symptom-free, the failure to assess each subject directly at the time of their completion of the DLCS was an omission. The possibility of some subjects tending towards depression or hypomania, therefore, cannot be excluded.

Although the comparison between depression-only and mania and depression subjects, using the DLCS, showed a statistically significant difference between the groups, this difference may not be clinically significant. The maximum possible score was 60, with subjects in both groups scoring as high as 53 on the scale, suggesting that they were very 'externalised'. The minimum possible score on the scale was 10.

The lowest score recorded for the depression-only group was 37, and 31 for the mania and depression group. It could be hypothesised that subjects with a previous history of mania would have possessed a heightened sense of control over their illness. The failure of any subject to score in a very internalised direction seems to refute this. The statistically significant difference between the two groups is based upon comparison of the means: 44.24 for the depression-only and 40.24 for the mania and depression group. Although a significant difference at the 0.01 level was evident, the groups did not project a highly externalised *versus* a highly internalised picture. If a cut-off point of 42 is used (mid-way between the two means) *eight* of the mania and depression sample (38%) score above this point, that is they showed more externalised scores than the rest of their group. Ten of the depression-only sample (42%) scored *below* this cut-off point. This analysis suggests that roughly similar proportions of each group showed scores which might be assumed to be more representative of their comparison group.

CHAPTER 12

DISCUSSION OF PART TWO

Three cognitive models of affective disorder were reviewed in Chapter 9. Differences between these models derive in part from interpretations of the nature and function of 'information-processing'. Another possible source of disagreement may stem from the inevitable conflict between studies drawn from *laboratory experiments* (Abramson *et al.*, *1978*), sociological *field studies* (Brown and Harris, 1978) and *clinical studies* in psychiatry (Beck *et al.*, 1980). In addition to the emphasis upon cognition, loss of reinforcement appears central to each model, despite differences in emphasis and interpretation. It was noted that 'reinforcement' might be defined as some form of pleasurable stimulus, but might equally be defined as 'any successful outcome'. Where pleasurable or necessary outcomes are not forthcoming, 'loss' may be the resultant experience.

Another perspective on the role of cognition in affective disorder, and the patient's relationship to outcomes, was offered with reference to the locus of control hypothesis. This perspective dealt specifically with the person's expectations of specific outcomes and their effect upon behaviour. The data presented in Chapter 10 suggest that women with a history of manic depressive psychosis (depression-only) are more fatalistic, in general, than a normative sample. The findings from the DLCS study in Chapter 11 suggest that such patients may have a similarly fatalistic view of the onset, course and likely recurrence of their depressive illness. This echoes Rosenbaum and Hadari's (1985) finding that depressives (*sic*)

expected outcomes to be controlled by chance, whereas a sample of paranoid subjects expected powerful others to exert influence over them. Using a measure of mastery, which was conceptually similar to Reid and Ware's (1974) 'self-control' factor, Walford-Kramer and Light (1984) found a statistically significant relationship between low mastery scores and depression (*sic*).

In Chapter 9, the terms 'attribution' and 'locus of control' were used to describe the possible mechanism of information-processing which is embraced by the term cognition. Palenzuela (1984) has observed a tendency, by different investigators, to define locus of control in different ways. Terminological and conceptual confusion has often resulted especially when the construct has been used inappropriately to measure other constructs. In a similar vein, Zuroff (1980) criticised the inappropriate merger between attribution and locus of control in some theoretical writings on depression. It has been noted that locus of control and attribution are conceptually *and* operationally different; locus of control involving a prior evaluation and attribution a retrospective evaluation of relationships. In view of these criticisms, the study of manic depressive psychosis subjects reported restricted its focus to locus of control in a general sense, with the SRI and BS sub-studies, and more specifically in terms of the DLCS data.

An attempt has been made in Part Two of the thesis to examine the target population from a psychological perspective, in an effort to clarify the possible role of psychological factors in the genesis or maintenance of depressive disorder. Although the findings are tentative, using Rotter's I-

E scale, in the form of the *Social Reaction Inventory*, support was evident for the hypothesis that depression-only subjects were more externalised than a normative sample. However, no significant difference existed between the mania and depression group and the normative sample, on this measure. The DLCS suggested that major differences existed between samples of depression-only and mania and depression subjects. However, these data were drawn from patients who were 'affectively well'. Consequently, it is not clear whether the same distinction would be evident in samples of clinically depressed or manic subjects. Indeed, these data represent measures of the locus of control construct in women at a particular time, when they were 'affectively well'. The measure should not, however, be interpreted as representing a trait or a typology, which will remain unchanged or fixed across time. The measures of locus of control elicited in sub studies 5 and 6, are *measures* of the locus of control construct, and are no more than rough approximations of the real and private thoughts which represent an individual's expectancies about control. However, bearing these reservations in mind, the small sample studied suggested that women with a diagnosis of manic depressive psychosis and a history of depression-only, report a vulnerability, even when affectively well, which is not evident in women with the same diagnosis but with a history of mania and depression.

The hypotheses, tested in Sub-Studies 5 and 6, dealt specifically with women, diagnosed as suffering from manic depressive psychosis, but who were not showing any overt symptoms of the disorder. The findings can , therefore, be used only in a limited way, to comment upon this particular clinical population. Further, these sub-studies dealt only with possible

correlations between specific psychological constructs and the construct manic depressive psychosis. Although certain psychological vulnerabilities appeared to be present within subjects described as having suffered from manic depressive psychosis, an evaluation of the causal relationship between these phenomena is not possible. Neither is it clear whether or not such characteristics are likely to change across time, in response to medical treatment or some other form of psychological manipulation. This question will be addressed in the Part Three of the thesis. The potential significance of psychological characteristics, such as 'high externality', for patients suffering from 'chronic' disorders has been commented upon by Wise and Rosenthal (1982) who noted that:

> ...patient's illness beliefs may be determined by a cognitive style such as locus of control rather than by the actual severity of the illness (p.252)

The assessment of the patient, in such psychological terms, had obvious clinical implications in their view, since:

> ...the externally located individual tends towards greater fear of vulnerability to illness, and has a greater conviction that he is ill, yet is less able to express anxiety and fear (pp 252-3).

Some support for these hypotheses is offered by the data reported in Chapter 10 which suggests that subjects, with a chronic history of depression, continue to think in a negative and fatalistic way, even in remission. Since self-blame was not specifically studied it is not clear, however, from these data whether or not this feature is present within the sample.

A tentative proposal can be made here of the possible significance of locus of control measures for the construction of models of affective disorder,

especially where repeated episodes of depression are involved. In Chapter 9 consideration was given to the use of attribution theory in the construction of models of affective disorder. Several studies were reviewed which suggested possible links between the subject's perception and interpretation of certain life events and subsequent disturbance of affect. The locus of control study reported here in sub-study 5 suggested that subjects with a diagnosis of manic depressive psychosis appeared to express a 'psychological vulnerability' in terms of fatalistic or 'defeatist' beliefs about their capacity to avert or reduce the likelihood of occurrence of similar negative events in the future. Given that the a proportion of the population studied might have experienced more than one previous affective illness, it is perhaps unsurprising that the belief systems, accessed through the locus of control scales, reflected fatalistic or 'defeatist' expectations about their capacity to control the repetition of more generalised negative events in the future.

By virtue of the fact that the subjects who comprised the study sample were long-term attenders at a Lithium treatment monitoring clinic, it can be hypothesised that even when 'affectively well' the subjects may have perceived themselves as 'manic depressive patients', since the medical adbvice given to such patients confirms their status as 'sufferers in remission'. The Norgine company, who publish a Lithium Therapy Guide* for use by patients make the following observation:

> Lithium smoothes out disabling mood swings, gradually restoring normality...The impression of "cure" is misleading, however. Lithium does not cure manic-depression, but it holds it in check (p.3).

It is assumed that most, if not all, patients diagnosed as suffering from

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* Camcolit Therapy Guide (undated). The Lithium Information Service. Norgine Limited, 116-120 London Road, Oxford OX3 9BA.

manic-depressive psychosis and offered lithium therapy as part of their overall treatment, will be offered this discretely medical conceptualisation of their illness. At the level of maximum speculation it might be assumed that subjects who perceive their mood, if not their overall functioning, to be 'permanently' under the control of a simple chemical salt, see themselves as unable to influence the kind of personal, interpersonal and social events defined in the locus of control scales. The development of the Depression Locus of Control Scale (DLCS) was reported in Chapter 11. This scale was developed in an attempt to describe patient's view of themselves as a 'sufferer' from a depressive illness. The subjects were invited, via the scale, to construct very specific interpretations of events which were relevant to past, and possible future, depressive illnesses. In this sense the subjects reported their 'locus of control' in relation to these highly specific events: that is, events associated with depressive illness. The data reported in Chapter 11 showed differences between mania and depression subjects and depression-only subjects. However, it was acknowledged that this statistical difference may not be clinically significant, as roughly equivalent numbers of subjects from the two groups scored below and above a cut-off point, established between the two group means.

The situational nature of locus of control is relevant to any consideration of the DLCS. Phares (1973) noted that whether one is internal or external may depend upon the area of one's life space which is being examined:

> To a black student, getting a job in a white man's world may be largely a matter of luck, but winning a basketball game with his peers may be largely under his own control (Phares, 1973, p.19).

The DLCS provides a highly specific measure of locus of control. Where a subject scored as highly externalised on this scale, one can assume, only, that this represented her locus of control in relation to these life events, at the time of the completion of the scale.

The DLCS was developed to provide the specific measure of locus of control noted above, in a format which would be acceptable to patients experiencing affective disorder. The results from the sub study suggest that the DLCS is a valid and reliable instrument, which will not prove too taxing for depressed subjects to complete.

Providing that the reliability of the DLCS can be demonstrated with a larger sample, this instrument might prove of most value as part of the assessment battery for depressed patients. The DLCS could be used to assess the attitude of the patient to her affective disorder, the results of which might have considerable bearing upon the kind of help she might be offered.

In the absence of a data describing DLCS scores across both acutely ill and patients in various stages of 'remission' from affective disorder, it is not possible to comment fully upon the clinical significance of the scores reproduced in sub-study 6. There is a need, therefore, to collect data from a larger sample of patients with diagnoses of affective disorder in general and manic depressive psychosis in particular. Sub-study 5 suggested that patients diagnosed as manic depressive psychosis, in remission, projected different kinds of 'psychological vulnerability', determined by histories of depression and mania, or depression-only. It would be appropriate to compare a wider range of patients with histories of affective disorder in

general, at various stages between the onset of an acute episode and the return to relative 'normality'. It could be hypothesised that some patients who experience an affective illness might construe this event as a piece of 'past history', which need not be repeated, or which they might prevent. Alternatively, other patients, such as the 'manic-depressive', may construe such events as only part of chain of events, which they can influence only by taking medication. The data presented in sub-study 6 was not adequate to distinguish patients with a history of mania and depression, from patients with a history of depression-only. At the level of maximum speculation it could be hypothesised that patients with certain kinds of affective disorder may perceive themselves to be more or less in control of themselves, compared with other sufferers from affective illness. Further studies need to be undertaken to test this hypothesis.

Conclusion

In Part Two psychological theories of affective disorder were reviewed against the background of bio-physiological explanations drawn from a medical perspective. The heterogenous nature of the diagnosis of depression was noted and an attempt was made to discuss possible distinctions between the various sub-categories of depression. Two sub-studies were reported which aimed to examine the psychological state of the target population: women suffering from manic depressive psychosis. Although the findings were variable, there were indications that psychological deficits were characteristic of such women, at least at the time of the sub studies. The scale of the sub-study samples was small thereby limiting the extent to which the findings might be generalised. However, these data suggest that cognitive style, in the form of locus of control, might prove an acceptable target for experimental manipulation of a clinical population.

PART THREE

CHAPTER 13

INTRODUCTION AND OVERVIEW OF PART THREE

As noted in the introduction to Part One, affective disorder in general, where disturbance of mood is the central feature, represents one of the largest group of disorders in psychiatry. Estimates of the probability of recovery for the first episode of manic depressive psychosis, in particular, range between 70 and 92 per cent. However, it is acknowledged also that relapse is likely in 60-70 per cent over a ten or 20 year period. Bebbington (1982) also noted that up to ten per cent of patients will remain in hospital as new long stay patients, with 25 per cent remaining with a milder clinical impairment and "a large number " remaining with significant social impairment. Outcome studies of bipolar patients, with a history of depression and mania, show that prognosis for this group is not uniform. Early studies showed a relatively low proportion of patients who were 'chronically disabled' (15% : Lundquist, 1945), compared with more recent studies (53% : Shobe and Brion, 1971). Some studies have described a better prognosis for unipolar patients, who experience *only* mania or depression (Bratfos and Haug, 1968; Shobe and Brion, 1971). More recent studies of a large cohort suggest similar recovery and chronicity patterns for unipolar and bipolar patients (Morrison et al, 1973; Tsaung et al, 1979). The validity of medical concepts such as 'recovery ' and 'chronicity' has, however, been questioned. Coryell and Winokur (1982) noted that most follow-up studies fail to distinguish between

presenting symptoms and social adjustment, and fail to seperate unipolar and bipolar patients when dealing with outcome prediction.

Medical Treatment

Numerous controlled trials have shown tricyclic and tetracyclic antidepressant medication to be the mainstay of treatment of affective disorder where depression is the predominant feature (Mindham, Howland and Shepherd, 1973). The value of lithium as a prophylaxis and antidepressant in manic depressive psychosis in particular (Goodwin and Zis, 1979) and has been reported as superior or equal to neuroleptics in the treatment of manic episodes (Coppen, Metcalfe and Wood, 1982). Convincing evidence exists of the effectiveness of ECT in the treatment of depressive episodes (Greenblatt, 1977) with similar response rates in unipolar and bipolar disorder (Stromgren, 1973). Where depressed affect is persistent - failing to respond to tricyclics and a course of ECT - Kendell (1983b) believes that "cognitive therapy may be worth a trial", but acknowledged that its efficacy in such patients has not yet been adequately assessed. Other interventions for resistant depression have included modified narcosis (*sic*) in conjunction with ECT and antidepressant drugs (Walter *et al.*, 1972) and psychosurgery (Lovett and Shaw, 1987). Studies have reported 60 per cent of depressed patients symptom free, or "much improved", following stereotactic surgery (Bridges and Bartlett, 1977). For some patients, it has been reported that psychosurgery has reduced the frequency of suicidal attempts, whereas other patients have remained unchanged (Goktepe, Young and Bridges, 1975). Checkley (1986) has suggested that in many

cases the optimal management of resistant depression is to persist with general, psychosocial and pharmacological principles of treatment:

> ...there is little evidence in favour of the wrongly labelled "heroic" forms of physical or psychological treatments (p.401).

Women and depression

It was noted in Chapter One that women occupy a peculiar position within the mental health/illness field. Although figures vary, women represent the majority of hospital and outpatient treatment populations for affective disorder, whether public or private (Howell and Bayes, 1982). This was as true in the seventeenth century, when women outnumbered men by two to one, as it is today (MacDonald, 1981). A study from the late 1960's found "more mental illness among women than men *from every data source*" (Gove and Tudor, 1973: emphasis added). No single explanation of this preponderance is universally accepted. The most popular traditional 'explanation' of this statistical fact has drawn a relationship between 'insanity' and 'femininity'. Feminist critics suggest that within our dualistic system of language and representation, women are typically associated with *irrationality, silence, nature and body. Alternatively, men are are associated with reason, discourse, culture and mind* (see Felman, 1975; and Lloyd, 1984). Where women assert their independence, and fail to conform to society's stereotype of *normal* female behaviour, such behaviour may be labelled as a sign of psychopathology (Rice and Rice, 1973). Chesler has argued that mental illness in women involves 'overconformity', or 'underconformity', to the prescribed female role:

> Men are not usually seen as "sick" if they act out the male role fully - unless, of course, they are relatively powerless contenders for "masculinity". Women are seen as "sick" when they act out the

> female role (are depressed, incompetent, frigid, and anxious) and when they reject the female role (are hostile, successful, sexually active, and especially with other women) [Chesler, 1972, p.118].

Although figures for the incidence of depression vary, women predominate. Two thirds of all psychiatric patients treated for depression are women (Wing and Hailey, 1972). For outpatient services, women outnumber men three to one. In a study of prescribing practice in Saskatchewan, Harding (1981) found that married women (20-29) were prescribed tranquillizers and sedatives four times more often than men of the same age, with antidepressants recording a ratio of eight to one in favour of women. These phenomenoma do not appear to be restricted to diagnosis and treatment. Studies of untreated depression, at least in urban areas, also report approximately two to one ratios in favour of women (Warheit, Holzer and Schwab, 1973). Brown and Harris's (1978) study of women in an inner London borough found that one third of women were equally depressed, or almost as depressed, as a group of women in active psychiatric treatment for depression. Studies of British, Scandinavian and North American samples document that between one quarter and one third of all women experience depression of moderate severity at some point in their lives (Klerman and Weissman, 1980).

A change in the peak age of onset of depression in women has been observed recently. Before 1945 this occurred after 40. A trend is now evident wherein the peak age of onset is during young adulthood (Weissman and Klerman, 1977). Beck (1979), the North American nurse, has suggested that this short-term trend may be a function of the 'women's movement', echoing Weissman and Klerman's (1977) suggestion

that recent rises in the rates of female depression stemmed from rising expectations, increased career and educational oppportunities, and attempts to remedy social inequalities. A number of studies have also shown that the predomination of women in the depressive population can be accounted for by married women (see Baumgart and Oliver, 1981; Coleman and Miller, 1975; Radloff and Rae, 1979). Porter (1970) found that 85% of a general practice depressed sample were women: an equivalent proportion of these patients were married. In this context, it would appear that marriage may function as a buffer against affective disorder for young and middle-aged men, whereas for women of the same age, marriage appears to exercise a detrimental effect, being associated with higher levels of depression than in unmarried women. The high proportion of married women within the female 'depressed' population, suggests that marriage may represent a source of stress, which increases the likelihood of a depressive illness. In a related context, affective disorder in retirement-age men, almost equals that of younger women, suggesting that the loss of employment status may have the same kind of detrimental effect upon men, as the existence of marital status has upon women.

Precipitating Factors

Various hypotheses have been proposed to account for the predominance of affective disorder among women. A popular viewpoint has been that the sex difference merely represents a greater willingness, on the part of women, to acknowledge and admit to coping difficulties. This hypothesis was rejected by Weissman and Klerman (1977) who argued that higher prevalence of female depression was a real and complex,

phenomenom. This supported Paykel, Prusoff and Uhlenhuth's (1971) finding that, despite some individual differences in ratings of how upsetting were certain life events, sex was not a significant distinguishing variable. More recently, however, a community survey of American adults (n=1,026) found only small differences between men and women for the most severe symptoms, a mixed pattern of differences for moderate symptoms and substantial differences:

> ...only for those symptoms judged by clinicians to be the ***least*** indicative of poor mental health, i.e. feelings of sadness (Newmann, 1984: p.146 emphasis added).

These findings supported the hypothesis that relatively mild, if not clinically trivial, symptoms of distress could account for the female preponderance in depression. Newmann acknowledges, however, that the scale used in the study (Dohrenwend *et al.*, 1980) taps themes of 'personal wrongdoing' and 'self-punitive urges' which might be more salient features of 'male depression'. These findings were challenged indirectly by Barrett, Oxman and Gerber (1987) in their screening of a general medical practice, where the incidence of low-level (non-clinical) depression in women was *one and half* that for men. At the higher level, the female to male ratio was 2:1. Newmann's study does, however, highlight what may be a more important issue: that sex differences in the reported incidence of depression may be, in part, a function of the depression scale employed.

Female hormones often have been implicated in the genesis of affective disorder. Handley, Dunn and Baker (1977) found raised blood tryptophan levels, correlating with affective disorder, four days postpartum. Given that such findings, however, have not been replicated by other

researchers, only by the original research team, their value remains uncertain. The traditional association been the menopause and affective disorder finds little support in the research literature (Weissman and Myers, 1978). Notman (1979) believed that the symptoms of the menopause were socially acceptable targets for the expression of stress associated with the mid-life period. From a psychodynamic viewpoint, affective disorder in mid-life probably results from the *psychological meanings* attributed to the phenomenom of the menopause, especially where the menopause was viewed as a signal of impending old-age, lost youth and beauty, or failed aspirations (Arieti, 1980). In a similar vein, Bowlby's (1985) object-loss theory led to the view that an interrupted, or unstable, relationship with the mother could lead to depression in adulthood. Studies suggest, however, that the impact of loss and change in a child's living conditions, such as poverty and conflicts, have a stronger relationship with wellbeing in adulthood (*cf.* Belle, 1982). Older psychological hypotheses, such as Freud's concept of depression as the internalisation of anger with accompanying guilt, although popular, have never been substantiated. As noted earlier, women receive little encouragement to express anger about events in their lives. Their dissatisfaction may, instead, be shown 'appropriately' through the helplessness' of depression.

The learned helplessness pathway, described in Chapter 9, suggested that the social conditioning of young women reinforces helplessness, with the female stereotype experiencing limited means of responding to stress. As noted earlier, other cognitive explanations parallel some of Seligman's hypotheses. The woman who meets with little 'success' in

life becomes sad. She may generalise this lack of success to her life in general, reaching a conclusion that this *means* that she is a failure. Largely as a result of social conditioning, she then reproaches herself for her failure, thereby heightening the feelings of sadness. Lewinsohn and Amensen (1978) suggested that depression is likely to occur in the presence of punishing events which fall into three categories: marital discord, work hassles and receiving negative reactions from others.

Psychotherapy and depression

Despite the emphasis upon treatment of depressive illnesses by drugs and ECT, assumptions about the role of psychological or social factors in the genesis of depression, have generated a wide range of psychotherapeutic methods. These range from the manipulation of highly specific phenomena, such as 'negative thinking' in cognitive therapy, to the more generalised interventions evident in group and family therapy. The use of 'traditional', psychoanalytic psychotherapy has been reserved almost exclusively for mild depression or, as Arieti (1980) observed, has been reported with only a few patients who were all treated in the intervals between depressive attacks. Shakir *et al.* (1979) found that lithium compliance was enhanced in bi-polar depressives offered long-term group psychotherapy. It was not clear, however, whether this gain was a function of the group process or the more consistent supervision possible through participation in the sessions. An earlier study by Davenport *et al.* (1976) found that the course of bi-polar disorder was more benign following discharge from hospital, if the patient participated in group therapy with the spouse.

In the case of less severe depression, Covi *et al.*(1974) found that patients who received a clinical trial of amitriptyline attained as much symptomatic relief as subjects who also received analytic group psychotherapy.

The interaction of depressive illness and social relationships has been noted as worthy of attention. Ludwig and Ables (1974) and Mayo (1979) have both reported the use of marital therapy as an adjunct to drug treatent. Ludwig and Ables reported increased stability and reductions in marital conflicts, seperations and job and home changes: all common life problems following unipolar and bipolar breakdowns. They argued for an extension of traditional treatment:

> ...our results indicate that the interpersonal context of manic depressive disorder should be more thoroughly studied. It seems highly likely that other humans interacting with a biologically susceptible individual may exert considerable influence on the initiation, alteration and perpetuation of excessive affective states. At a level of maximum speculation they may imply mutual, non-verbal, subconscious "biochemical communication" between two intimate individuals can occur not only altering their internal biological milieu but subtly altering their behaviour as well (Ludwig and Ables, 1974).

Such findings led Klerman and Schechter (1982) to suggest that the combination of drugs and psychotherapy in bipolar disorder, showed promise, but was a relatively neglected area of research.

Interpersonal therapy (McLean, 1976; Klerman *et al.*, 1984) is a highly structured form of counselling directed at assisting problem-solving of present difficulties, rather than dealing with influential past experiences. Klerman *et al.* (1974) compared interpersonal therapy with 'supportive interviewing', as a continuation treatment for patients

receiving amitriptyline, placebo, or no drug. At one year follow-up, the interpersonal therapy group showed better social functioning than those receiving support only, but were no less likely to have been depressed. A subsequent comparison by Weissman *et al.* (1979) of interpersonal therapy, amitriptyline and a combination of these two, showed that acutely depressed patients improved equally under antidepressant and interpersonal therapy and both conditions were significantly better than the supportive interviewing. The combined treatment showed better results than either therapy alone, but this was not statistically significant. McLean and Kakstian (1979) found that patients receiving interpersonal therapy showed a lower drop-out rate and made greater gains on nine out of 10 outcome measures at the end of therapy, when compared with traditional psychotherapy, antidepressant therapy and relaxation. However, at three month-follow-up, the interpersonal group were only marginally superior. Rehm's (1977) self-control therapy, which focussed even more specifically on teaching self-monitoring, self-evaluation and self-reinforcement techniques, was more effective than non-specific group therapy and a waiting list control (Fuchs and Rehm, 1977) and social skills training (Rehm *et al.*, 1979). Roth *et al.* (1982) reported that a combination of self-control therapy and antidepressant medication produced more rapid improvement than self-control alone.

Cognitive therapy involves interventions which focus more specifically upon changing depressogenic cognitions. Beck and his colleagues were the first to report the advantages of this approach over antidepressant therapy, in the case of less severe depression in a non-hospital

population (Rush *et al.*, 1977). Follow-up studies of patients receiving cognitive therapy show maintenance of gains, and lower drop-out rates (Kovacs *et al.*, 1981). Blackburn *et al.* (1981) found that cognitive therapy was minimally more effective than pharmacotherapy for an out-patients department sample, with a combination of these two treatments showing an additive effect. In a general practice sample, cognitive therapy alone and in combination with drugs, was superior to drugs alone. A later study by Murphy *et al.* (1984), involving a similar sample, failed to replicate the finding that the addition of cognitive therapy enhanced the pharmacotherapy.

On the basis of available evidence, the role of psychotherapy in the treatment of severe depressive disorder is unclear. Many studies indicating the superiority of psychotherapeutic methods have involved either very small samples or the study of mildly depressed volunteers recruited through advertisements. The paucity of controlled studies of more severely, and chronically depressed, subjects has been noted. It would also appear that various methods have achieved similar success rates over drugs, waiting list control conditions, or more generalised psychotherapeutic interventions, such as group therapy or social skills training. This may be due to the sharing of some psychological factor, such as a structured approach to problem-solving, organised involvement in naturally reinforcing activities and the gradual shaping of the patient's expectations of recovery. In this vein Zeiss *et al.* (1979) suggested that the 'critical components' of cognitive-behavioural therapy for depression might be:

1. The use of a ***well-planned rationale*** which guides the patient towards the belief that (s)he can control her/his own behaviour,
2. ***Significant skills training*** to help the patient feel more effective in handling her/his daily life,
3. An ***independent skill-use structure*** to encourage the practice of coping methods outwith therapy, and
4. ***Attribution manipulation*** to encourage recognition that mood change results from the patient's increased skillfulness.

From the perspective of dynamic psychotherapy, Arieti (1980) suggests that indications for psychotherapy exist in every case of 'severe depression' (*sic*) and that prior or concomitant drug therapy or ECT do not make the patient less accessible to psychotherapy. Contrary to common practice, Arieti recommends psychotherapy strongly for hospitalised patients, especially where physical treatments have been ineffective or where the disorder is recurrent.

The Main Study : Experimental Design

A summary of the practice of nursing patients with affective disorder was provided in Part One, by reference to the nursing literature, through an analysis of the Scottish psychiatric nurse training programme and from descriptions of nursing practice contained in a sample of Scottish nurses' self-reports. The traditional nursing approach to the care of this population appears to involve a special relationship between nurse and patient. The nurse tries to reduce distress actively by *reassurance* and *encouragement*, helping the patient

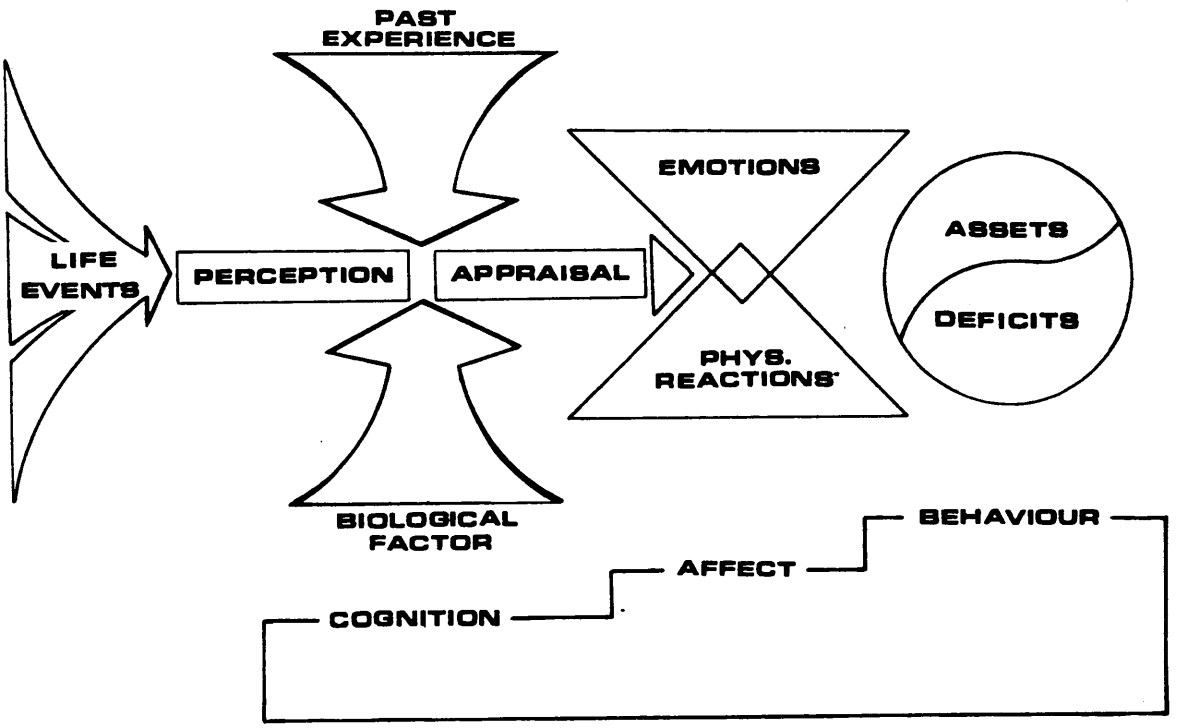
to 'discharge' other unpleasant feelings through conversation about life events. The conclusions reached in Part One echo Hein's (1980) view that nurse-patient interaction is aimed at the production of 'therapeutic communication', which differs from everyday communication in the sense that it is a planned approach, aimed at influencing the patient in a direction which serves her interests and welfare. In the main study reported in Chapters 14 - 16 of Part Three of the thesis, an attempt was made to evaluate the effect of this traditional role, comparing it with two, more specifically defined, relationships with depressed patients.

In Part Two a description was offered of some contemporary models of depression, each of which emphasises the role of congition as a mediational process, translating life events into depressive symptomatology. The experimental study reported in Part Three of the thesis, was based upon the assumption that cognitive processes played some part in the genesis of depressed mood in patients diagnosed as suffering from manic depressive psychosis. Although this assumption reflected the view of the cognitive theorists reported in Chapter 9, the author acknowledges that such a view is hardly exclusive to cognitive theorists. Contemporary dynamic psychotherapists, for example, also have emphasised the central role of "depression-prone cognitive components" (Arieti 1978; p. 220)

Outline of a hypothetical model of affective disorder

The author's conceptual model upon which the study was based is shown in Figure 13.1. The model conceptualises the clinical features of depression as the end result of a process which begins with the patient's response to events which occur in her life. The model assumes that the patient *interpretation* of these events involves a number of *perceptual* errors, where she ignores or censors positive experiences of self or the world, focussing instead upon negative experience or personal inadequacy. At the same time, or soon after, the model assumes that the patient may make *judgemental* errors, by exaggerating the importance or significance of certain events, or minimising her own capacity to deal with such events, or more generally in devaluing her skills or accomplishments. These negative cognitions generate different kinds of affective disturbance, experienced on a *psychic* level as guilt, sadness or despair; and in *somatic* terms as lethargy, pain or tension. These emotional reactions inhibit the performance of 'normal' coping responses, stimulating instead the display of patterns of behaviour which represent passivity, helplessness or other responses which might be characterised as 'illness' behaviour.

Figure 13.1 Hypothetical Model of Affective Disorder



The conceptual model acknowledges the role played by past experience, or learning, in fostering the negative thinking style which mediates between life events and their emotional sequelae. It also acknowledges that biological or biochemical processes, as yet not fully understood, can also affect the patient's thinking style and ultimately her feelings. The model describes affective disorder as the behavioural outcome of affective disturbance, which is a function of the interaction of present cognitive errors, past experience (or learning) and the patient's biophysical make-up.

The model assumes that, where the affective disorder is chronic in nature, the focus of the patient's perceptual and judgemental errors

are upon her own behaviour, rather than the original 'triggering' life events. The model hypothesises that the behavioural manifestation of affective disorder is maintained by a 'vicious circle' which involves dysfunctional pereception and appraisal of the patient's behavioural state, which increases or maintains affective disturbance, which in turn maintains or exaggerates the behavioural deficits associated with affective disorder, which in turn is re-appraised negatively by the patient, setting the cycle in motion once more.

Aims of the Main (Experimental) Study

The main (experimental) study aimed to answer the following questions:

i) ***What effect do specific forms of nursing intervention have upon the manic depressive patient's perception of herself in relation to her condition?*** As reported in Part Two, women diagnosed as suffering from manic depressive psychosis, when 'in remission', can be distinguished from a normative sample in terms of their locus of control scores. This may serve as a process factor in the development of further depressive episodes. In Chapter 11, a measure of the patient's 'depression locus of control' was described. In the main (experimental) study reported in Part Three of the thesis, an attempt was made to monitor this measure of cognitive style, across time and across different nursing interventions. The study's research hypothesis predicted that subjects receiving the 'traditional' or *Routine Nursing Care* (RNC) and a *Self Evaluation (SE)* programme of care would show no significant change between baseline, discharge and follow-up, whereas the scores of subjects exposed to a nursing intervention described as *Modified*

Cognitive Therapy (MCT) would become more internalised at discharge and follow up.

ii) ***What effect do these forms of nursing intervention have upon other measures of the manic depressive patient's pathological state?*** Three features are typically regarded as important characteristics of the presence of, or susceptibility to, affective disorder. These are : reports of negative affect (Beck *et al.*, 1961); reports of negative thoughts (Hollon & Kendall, 1980); and underlying dysfunctional beliefs (Weissman and Beck, 1978; Burns, 1980). The main (experimental) study reported in Part Three of the thesis, aimed to compare the effect of the three nursing interventions (RNC, SE and MCT)on these features of affective disorder. In addition to monitoring any change across time and conditions, the main study aimed to establish whether or not the subjects' scores returned to within 'normal limits' on remission, when compared to an appropriate normative population. The research hypothesis of the main study predicted that subjects exposed to the *Routine Nursing Care* and *Self Evaluation* interventions would show no significant positive changes in their scores on these three measures, whereas the scores of subjects exposed to the *Modified Cognitive Therapy* intervention would show a significant positive change at discharge at follow up.

iii) ***Do manic depressive patients perceive any difference between the kinds of nursing intervention offered, and the role of nurses involved in the delivery of their care?*** As described in Part One, the traditional role of nurses caring for depressed people involves

offering general psychosocial support as an adjunct to medical intervention. Two alternatives to this traditional role were offered in the main (experimental) study: the Self Evaluation (SE) and the Modified Cognitive Therapy (MCT)interventions. The research hypothesis of the main study predicted that subjects receiving the *Modified Cognitive Therapy* would comment more favourably upon their overall care, by comparison with subjects receiving the *Routine Nursing Care* and *Self Evaluation* interventions.

CHAPTER 14

THE MAIN (EXPERIMENTAL) STUDY : METHOD

Overview of the experimental design

The experiment used an unrelated, randomised subjects design (Kerlinger, 1986). Three independent variables were defined:

i) Routine nursing care (RNC),

ii) Self evaluation (SE) and

iii) Modified cognitive therapy (MCT).

Five dependent variables were identified. These represented self-report ratings of:

1. depression,
2. negative automatic thoughts,
3. dysfunctional beliefs,
4. locus of control and
5. satisfaction with care and treatment.

The measures of the dependent variables are summarised in Table 14.1.

Table 14.1 Measures of dependent variables

Dependent Variable	*Measure of Dependent Variable*
1. Depression	Beck Depression Inventory (BDI).
2. Negative automatic thoughts	Automatic Thoughts Questionnaire (ATQ30).
3. Dysfunctional beliefs	Dysfunctional Attitude Scale (DAS)
4. Locus of control	Depression Locus of Control Scale (DLCS).
5. Satisfaction with care and treatment	Patient Satisfaction Scale (PSS).

Four of the dependent variables (depression, negative automatic thoughts, dysfunctional beliefs and locus of control) were assumed to represent significant *characteristics of affective disorder*.

The main study's research hypotheses predicted that no significant difference would exist between subjects exposed to the independent variables, Routine Nursing Care (RNC) and Self Evaluation (SE) on all five measures of the dependent variables. The main study also hypothesised that subjects exposed to the independent variable Modified Cognitive Therapy (MCT), would show significantly greater improvement, on all five measures of the dependent variables, than either of the other two groups (RNC and SE).

Selection and allocation of subjects

The recruitment of research subjects and their subsequent allocation to the three experimental conditions (RNC, SE and MCT) was as follows:

1. Women with affective disorder were admitted to the ward from home or transferred from other wards within the psychiatric service. On admission, each patient was interviewed by two psychiatrists independently, using the Feighner Criteria (Feighner *et al.*, 1972). Patients who satisfied the following criteria were considered eligible for inclusion in the study*. Subjects for the main (experimental) study were required to have had:

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* An outline of the study, including the criteria detailed here, was approved by the Research Sub-Comittee of the Health Board, within whose area of jurisdiction the study was mounted.

i) at least one previous hospital admission for treatment of manic depressive psychosis,

ii) No receipt of electro-convulsive therapy (ECT) within the previous six weeks.

iii) a diagnosis of 'primary affective disorder: depression' on the Feighner *et al.* (1972) Diagnostic Criteria, made by two psychiatrists, interviewing the patient independently. (These research diagnostic criteria were used routinely, for the selection of subjects for psychiatric research studies within the ward). A recent study (Coryell and Zimmerman, 1987) compared three diagnostic systems: Feighner *et al.*'s criteria, the Research Diagnostic Criteria (Spitzer *et al.*, 1978) and the Diagnostic and Statistical Manual III (American Psychiatric Association, 1980). The authors confirmed the validity of these three 'competing' systems noting that their results "do not, moreover, support any one system over the others (p.1472)"

The patient was required to meet the following three criteria (summarised from Feighner *et al.*, 1972: p.58):

A) Dysphoric mood characterised by symptoms such as, depressed, sad, blue, despondent, hopeless, "down in the dumps", irritable, fearful, worried or discouraged.

B) *At least* five of the following: 1) poor appetite or weight loss, 2) sleep difficulty (insomnia or hypersomnia), 3) loss of energy, 4) agitation or retardation, 5) loss of interest in usual activity or decrease of sex drive, 6) feelings of self-reproach or guilt (either may be delusional), 7) complaints of, or diminished ability to think or concentrate, 8) recurrent thoughts of death or suicide.

C) A psychiatric illness lasting at least one month, with no preexisting psychiatric conditions such as schizophrenia, anxiety neurosis, phobic neurosis, obsessive-compulsive neurosis, hysteria, alcoholism, drug dependency, antisocial personality, homosexuality and other sexual deviations, mental retardation or organic brain syndrome.

2. A routine nursing assessment was conducted on all patients as soon as was convenient after admission (Hume, Barker & Robertson, 1985). This included an informal assessment of the patient's motivation to participate in the research programme. Patients who gave informal (verbal) consent to inclusion in the study were discussed further at the medical/nursing team meeting. Patients classed as eligible were allocated a code number, based on their admission order, and assigned to a waiting list.

3. Prior to transfer to the study, the patient's key nurse (who was responsible for the co-ordination of her care) explained the background to the research programme. The voluntary nature of the patient's involvement was explained and her written consent sought (see Appendix 12). The patient's right to withdraw from the study at any stage was emphasised.*

4. The psychiatrist in charge of the patient's case was notified formally of her inclusion in the study (see Appendix 13) and a written record entered in the patient's nursing notes.

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* Six patients declined to participate and were offered the routine nursing and medical care afforded by the ward

5. Participating subjects were allocated to one of the three experimental conditions, Routine Nursing Care (RNC), Self Evaluation (SE) or Modified Cognitive Therapy (MCT), on the basis of their code number. Allocation to the three experimental conditions was determined in advance by the author using random number tables. Introduction of the subjects to the study varied between the first few days and the end of the second week after admission. Entry date was determined by the number of subjects in 'active' treatment and the availability of nursing personnel to operate the experimental intervention.

Measures of the dependent variables

Five measures of the five dependent variables were involved in the study. Four involved measures of clinical characteristics assumed to be relevant to the construct of affective disorder. The fifth related to the subjects' perception of the care and treatment received. All measures of the dependent variables involved self-report ratings.

Prior to the commencement of the study two direct observational methods had been tested on the ward, in an assessment of their possible role as measures of one of the dependent variables. The time-sampling method described by Williams, Barlow and Agras (1972) is a direct observational method for the measurement of the behavioural characteristics of affective disorder. This format was tested over a three-week period. Using nurse observers from the ward team, inter-observer reliability failed to achieve an acceptable level. The design of the living environment, which comprised various rooms, corridors, toilet areas, bathrooms and three dormitories, made direct observation

of the subjects difficult using this time-sampling method. A revised version of this format, which allowed for some of these geographical features, was developed by the author and tested over a further two-week period. However, due to the subjects' relative freedom of movement within the environment, a low percentage of total observations was recorded and inter-observer reliability remained low. In view of the difficulties met in the use of these direct observational methods and in consideration of the experiential nature of depression, a decision was taken to use only self-report measures in the experimental study.

The measures used in the assessment and evaluation of the subjects are described below. Measures 1 - 4 were completed by the patient, under the supervision of a nurse, on admission to, and discharge from, the main study. These four measures were also completed under nursing supervision at a follow-up interview held in the patient's home, six months after discharge. Each of these four measures is described below in terms of the content of the measure, reported reliability and validity and a simple rationale for its inclusion as a measure of the dependent variable.

The subjects were also given the Patient Satisfaction Scale (PSS) at the follow-up evaluation. Each subject was asked to complete this independently and to return the scale in a stamped addressed envelope to the author.

1. *The Beck Depression Inventory (BDI):* This scale measured the dependent variable *depression*, expressed by one of the following attributes:

1. Specific mood change,
2. Negative self-concept associated with self-reproach and self-blame,
3. Self-punitive wishes,
4. Vegetative changes and
5. Change in activity level.

The scale comprised 21 items, each involving four self-evaluative statements defined by a four-point (0 - 3) ordered scale (see Appendix 14). The subject was asked to identify the response to each item which most reflected herself over the past week, including the day of completion of the scale. The possible scores ranged from 0 to 63. The item representing 'guilt', shown below, is typical of the scale overall:

0 I don't feel particularly guilty
1 I feel guilty a good part of the time
2 I feel guilty most of the time
3 I feel guilty all of the time.

The original scale was designed to be scored by an interviewer (Beck *et al*,. 1961). The self-report version used in the study was described by Beck and Beamesderfer (1974). The items were derived from systematic observation of the distinguishing characteristics of depressed patients. Those characteristics which appeared to be specific for

depression, and which were consistent with descriptions in the psychiatric literature, were selected. In Beck *et al.*'s (1961) original study, a panel of psychiatrist judges offered a consensus view of the severity responses to each item, as part of the validation of the instrument.

Beck and Beamesderfer (1974) reported on the development of the scale. The split-half reliability coefficient of 0.93 was computed using the Spearman-Brown formula (n=97). The stability of the scale was tested by repeated administration over a four-week period: changes in BDI scores paralleled changes in clinicians' ratings. Concurrent validity was tested by correlating the BDI with the Hamilton Rating Scale for Depression (Hamilton, 1967)[r = .75]; and Zung Self-Rating Depression Scale (Zung, 1965)[r = .76]. The normative data reported by Beck and his colleagues were used as a comparison for the study population.

Although all subjects had already been *diagnosed* as suffering from 'primary affective disorder: depression' by two psychiatrists, this measure provided data on the subject's *experience* of depression. The BDI provided a format for classifying subjects in terms of levels of 'severity' of depression, by comparison with existing norms.

2. *The Automatic Thoughts Questionnaire (ATQ30):* This scale measured the frequency of occurrence of the dependent variable *negative automatic thoughts* (negative self-statements) associated with depression. The scale, which was developed by Hollon and Kendall (1980), requires subjects to rate the frequency of occurrence of thirty

thoughts over a one-week period using a five-point (1 - 5) ordered scale: 1 = "not at all" to 5 = "all of the time" (see Appendix 15). The item pool was generated from a student sample (n=788) who described thoughts which "just popped into their heads" during 'depressing' episodes. A sample of 100 representative thoughts were adminstered to a second sample (n=312) who also completed the BDI and the MMPI-D (Hathaway & McKinley, 1943). Thirty items which discriminated between depressed (n=12) and non-depressed (n=20) subjects were identified in the final scale.

Correlations between the ATQ-30, the BDI and the MMPI-D, using the full sample were statistically significant ($p < 0.01$). Split-half and coefficient alpha (Richardson and Kuder, 1939) reliabilities were .97 ($p < 0.001$) and .96 ($p < 0.001$) respectively. Item-to-total correlations were significant at the 0.001 level or beyond for all thirty items. Hollon and Kendell's study surveyed only young university students (mean age 20.2 years [SD = 4.34]).

Normative sample. To allow for the possible effects of age on scoring, a normative sample, was drawn by the author from a female non-clinical community population (n=107), as a comparison group for the outcome evaluation. The sample subjects were drawn using random number tables from a pool of approximately 350 nurses who were employed within the health district within which the main (experimental) study was implemented. The nurses comprising the sample pool were tutorial staff in a College of Nursing, and Nursing Officers and clinical nurses, from one psychiatric and one mental handicap hospital. The subjects

were invited to complete the ATQ30 as "part of a wider nursing research project". The subjects completed the scale anonymously, noting only their age and occupational status. The sample (n=107) represented the nurses who responded to the invitation to participate in the normative study, by returning completed copies of the scale. The age range of the sample was 22 - 57 years ($\bar{X}$=36.4). The classification of the occupational status of the sample is shown below:

1. Senior trained nurses: this comprised tutors, clinical teachers, nursing officers and Ward Sisters (25% of total sample).

2. Trained nurses : registered mental nurses, registered mental handicap nurses and state enrolled nurses (29%).

3. Untrained nursing staff: nursing assistants (46%).

The ATQ30 provided a format for collecting discrete data on negative automatic thoughts, which have been reported to have a positive correlation with affective disorder.

3. *The Dysfunctional Attitude Scale (DAS):* This scale measured the dependent variable *dysfunctional beliefs.* The scale was developed by Weissman and Beck (1978) to measure beliefs which were assumed, under Beck's cognitive theory of depression (Beck, 1967), to constitute predispositions to depression. The original scale comprised 100 items. Abbreviated parallel forms of the scale, described as DAS and DAS-B, have been developed using factor analysis. Reliability reported for a student sample (n=70) was .86 [DAS] and .87 [DAS-B] (Weissman amd Beck, 1978). Validity studies with students suggest a satisfactory level of correlation between the 100-item scale and the BDI (r=0.65)

A shortened, 35-item version of the Dysfunctional Attiude Scale was described by Burns (1980) and has been used in research with psychiatric subjects (Durham and Turvey, 1987). This shorter and simplified scale was considered more appropriate for the sample subjects, most of whom could be expected to be suffering from concentration difficulties (see Appendix 16). The scale asked the subjects to respond to 35 general statements which reflected beliefs about human relationships and social life: for example, "criticism will obviously upset the person who receives the criticism". Each item was rated using a 5-point (1 - 5) ordered scale: 1 = "agree strongly" to 5 = "disagree strongly". The resultant total score provided an indication of the level of 'psychological strength' (high score) or 'emotional vulnerability' (low score) shown by the individual.

Normative sample. Normative data for this shortened version of the DAS was obtained from the female, non-clinical sample reported under the ATQ30 on the previous page. A larger proportion of the normative sample returned completed versions of the shortened DAS (n=124). The proportions of the sample within the three occupational classes, however, was similar to that reported for the ATQ30 survey: Class 1, 22%, Class 2, 28%, Class 3, 50%.

The shortened DAS provided a simple means of collecting discrete data on dysfunctional beliefs which, within Beck's (1967) theory of affective disorder, constitute predisposing factors for the stimulation of negative automatic thoughts and, subsequently, depressed affect.

4. *The Depression Locus of Control Scale (DLCS):* This measured the dependent variable *locus of control*. This 10-item scale measured the subjects' view of herself as a 'depressed person', in terms of assumed levels of 'internality' (low score) and 'externality' (high score). The development of the scale, along with reliability and validity data, were presented in Chapter 11 in Part Two of the thesis.

The DLCS provided a simple means of collecting discrete data on locus of control. In Rotter's (1966) view the existence of highly externalised scores suggested an emotional vulnerability, which might predispose the subject to feelings of helplessness and subsequently depressed affect.

5. *The Patient Satisfaction Scale (PSS):* This measured the dependent variable *satisfaction with care and treatment*. The PSS was a 35-item scale designed to assess the subjects' appreciation of the care and treatment received during their stay within the project. Subjects were asked to complete this measure independently, following the six-month follow up. The scale was a revision of a similar scale developed by McGivern (1972) and was adapted with the full permission of the author (McGivern, 1983). Subjects were asked to evaluate various aspects of the organisation and delivery of care and treatment (see Appendix 17). Each item was rated using a 0 - 4 scale. Levels of 'satisfaction' were classified by the author as follows:

'very dissatisfied' : 0 - 35
'dissatisfied' : 36 - 70
'satisfied' : 71 - 105
'very satisfied' :106 - 140

Normative data on the PSS has not been reported.

The Hypotheses

Null Hypothesis 1. Measures of depression on the BDI will not differ significantly between groups RNC, SE and MCT at discharge.

Research Hypothesis 1. The MCT group will yield lower BDI scores than RNC or SE at discharge

Null Hypothesis 2. Measures of depression on the BDI will not differ significantly between groups RNC, SE and MCT at follow-up

Research Hypothesis 2. The MCT group will yield lower BDI scores than RNC or SE at follow-up.

Null Hypothesis 3. Measures of negative automatic thoughts on the ATQ30 will not differ significantly between the three groups RNC, SE and MCT at discharge.

Research Hypothesis 3. The MCT group will yield lower scores on the ATQ30 than RNC or SE at discharge.

Null Hypothesis 4. Measures of negative automatic thoughts on the ATQ30 will not differ significantly between the three groups RNC, SE and MCT at follow-up.

Research Hypothesis 4. The MCT group will yield lower scores on the ATQ30 than RNC or SE at follow-up.

Null Hypothesis 5. Measures of dysfunctional beliefs on the DAS will not differ significantly between the three groups RNC, SE and MCT at discharge.

Research Hypothesis 5. The MCT group will yield higher DAS scores than RNC or SE at discharge.

Null Hypothesis 6. Measures of dysfunctional beliefs on the DAS will not differ significantly between the three groups RNC, SE and MCT at follow-up.

Research Hypothesis 6. The MCT grou will yield higher DAS scores than RNC or SE at follow-up.

Null Hypothesis 7. Measures of locus of control on the DLCS will not differ significantly between the three groups RNC, SE and MCT at discharge.

Research Hypothesis 7. The MCT group will yield lower, more internalised, scores on the DLCS compared with the RNC and SE groups at discharge.

Null Hypothesis 8. Measures of locus of control on the DLCS will not differ significantly between the three groups RNC, SE and MCT at follow-up.

Research Hypothesis 8. The MCT group will yield lower, more internalised, scores on the DLCS compared with the RNC and SE groups at follow-up.

Null hypothesis 9. Measures of satisfaction with care and treatment on the PSS will not differ significantly between the three groups at follow-up.

Research Hypothesis 9. The MCT group will show higher scores on the PSS than RNC or SE at follow-up.

Data analysis

All data generated from the study were in the form of ordinal scores. Consequently, all analyses involved non-parametric tests.

Analysis of uncontrolled variables. Between group comparisons of *age* and number of *previous hospital admissions* of all subjects, on admission to the study, were analysed using Kruskal-Wallis One-way Analysis of Variance by Ranks (Seigel, 1956). Retrospective analyses of *drug treatment* offered to each subject, and *length of stay* within the study for each subject, were undertaken at follow-up using the same Kruskal-Wallis between groups comparison.

Analysis of measures of dependent variables. All three groups were compared in terms of within-groups changes between admission and discharge scores on all measures, using Wilcoxon Matched-Pairs Signed Ranks Test (Seigel, 1956). Where significant differences existed between the three groups, paired comparisons were undertaken on each dependent variable, using the Mann Whitney U Test (Seigel, 1956). Here, two comparisons were made between the two groups which showed the greatest apparent difference when the data were presented graphically.

The significance level for each two-tailed test was set at the .05 level; one-tailed tests set at .025.

Clinical significance. Jacobson, Follette and Revenstorf (1984) proposed a *reliable change index* (RC) in an effort to objectify the concept of 'clinically significant change'. Their RC was equivalent to

the difference score (post minus pre) divided by the standard error of measurement of the dependent measure:

$$RC = (\chi_2 - \chi_1)/S_E$$

where S_E = standard error of measurement;

χ_1 = pretest score;

χ_2 = posttest score.

These authors recommended use of the following forumla for calculation of the standard error of measurment:

$$S_E = s_1\sqrt{1 - r_{xx}}$$

where s_1 = the standard deviation;

r_{xx} = the reliability of the measure.

Christensen and Mendoza (1986) proposed a correction of this formula using the *standard error of difference* between the two scores rather than the standard error of measurement which, they argued, relied upon access to the subject's *true* pretest score. Their *significant change index* (SC) subsequently was accepted as "entirely appropriate" by Jacobson *et al.* (1986) and used the following formula:

$$SC = \frac{X_2 - X_1}{S_{diff}}$$

where S_{diff} = standard error of difference between two test scores: viz.

$$S_{diff} = \sqrt{2(S_E)^2}$$

Christensen and Mendoza's SC index was used to evaluate the level of clinically significant change occurring within each group on each dependent measure. Christensen and Mendoza (1986) suggested that where:

> SC >±1.96...one would conclude that the pre- to posttest change is (probably) not due to measurement error alone but is a *real* change in the true score due to experimental treatment (Christensen and Mendoza, 1986 p.307).

The SC index was used to evaluate the level of clinically significant change occurring within each group on each dependent measure, using ±1.96 (.05 level) as the cut-off point.

The subjects

Thirty subjects completed the course of the study up to, and including, a six-month follow up after discharge from the ward. A sample of 45 subjects (3 groups of 15) was the original target. Eight subjects who agreed to participate in the study were withdrawn at some point following their commencement. Four subjects were given a course of ECT (1XRNC, 1XSE, 2XMCT) and four asked to withdraw prior to discharge (two each from RNC and SE). In order to complete the project on schedule the study closed when ten subjects had completed each experimental condition.

All subjects were diagnosed as 'primary affective disorder: Depression' on the *Research Criteria* of Feighner *et al.* (1972). The consultant psychiatrist confirmed that, **in the case of the research subjects,** this research diagnosis was synonomous with the ICD (WHO, 1978) diagnosis of manic depressive psychosis (Naylor, 1987). All subjects were receiving drug therapy on admission to the ward. This was adjusted to conform to a prescription agreed between the author and the consultant psychiatrist of the ward whereby a standardised list of antidepressant

drugs was used as the sole basis of medical intervention. This procedure guaranteed a degree of uniformity of medical treatment across all subjects. No subject had received ECT within two months of her admission to the study. All subjects, including withdrawals and drop-outs, were female.

The composition of the three groups is illustrated in Table 14.2. A vignette of one subject from each of the three groups is provided in Appendix 18. The mean age of subjects in the SE group was higher than the means of the other two groups, but this was not significant (H=4.8, d.f.=2, *ns*). No significant difference was evident either for numbers of previous admissions (H=0.05, d.f.=2, *ns*).

Table 14.2 Composition of the Experimental Groups: Age on admission and previous number of admissions.

Routine Nursing Care			*Self Evaluation*			*Modified Cognitive Therapy*		
Subject	Age	P.A.		Age	P.A.		Age	P.A.
1.	48	5	1.	70	2	1.	30	2
2.	36	3	2.	69	8	2.	34	4
3.	36	11	3.	36	11	3.	35	5
4.	53	3	4.	59	6	4.	39	4
5.	42	2	5.	35	5	5.	68	4
6.	46	4	6.	62	3	6.	72	6
7.	35	5	7.	70	2	7.	38	4
8.	34	2	8.	53	2	8.	34	2
9.	51	2	9.	40	3	9.	28	4
10.	28	3	10.	37	2	10.	37	2
$\bar{X}$ =	40.9	4		53.1	4.4		41.5	3.7
S =	8.3	2.7		15.1	3.1		15.4	1.3

Procedure

Subjects were allocated randomly to one of three experimental groups. No attempt was made to match subjects across conditions. The experimental groups were as follows:

RNC: Routine Nursing Care group subjects received a programme of care involving interactions similar to those described in the nursing literature review, the analysis of the training literature and the critical incident survey reported in Part One. Given the apparent similarity between the descriptions of 'routine nursing care' reported in the study of the ward team (see Chapter 6) and the descriptions of nursing care in the literature and the other two sub-studies, the traditional practice on the ward was accepted as typical of 'routine nursing care' in general. This intervention was described as an 'experimental' manipulation, since the control exerted over time spent with the subject, content of the interaction and the nurse's attitude towards the patient' as a subject, may well have distinguished this intervention from the 'routine care' offered to patients not involved in the main study.

The general format of care involved a *regularisation* of the interactions reported in Chapter 6, as follows. Each day, a nurse would contact the subject, enquire in general terms about her psychological and physical state and invite her to identify a topic for discussion. Usually this involved discussion of the subject's feelings, problems encountered on the ward or which awaited her on discharge. The nurse concentrated upon helping the subject to identify and express her

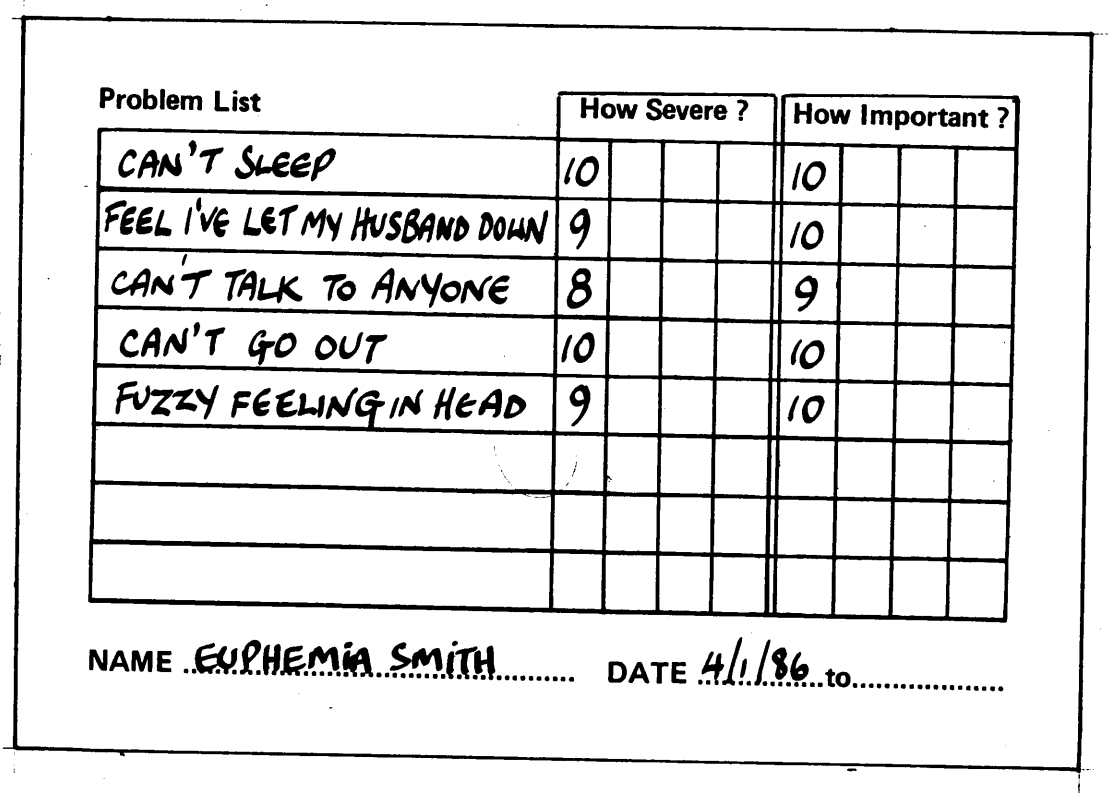
feelings; describe her problems; provide reassurance and general support; and help her to work out ways of dealing with her problems, giving advice if requested, or if the nurse thought this would be appropriate. This interaction was entirely verbal. Apart from 'logging' the time spent in the interaction, and recording any important information in the nursing notes, no written records of any kind were maintained.

If the subject did not wish to discuss her 'illness' or its concomitants, the nurse suggested that they might engage in some activity or have a conversation on other, more general topics.

SE: *Self Evaluation* group subjects were approached initially in the same manner as RNC above, and invited to set an agenda for discussion. Once the subject had identified a problem, she was encouraged to summarise this in writing on a card (see Fig.14.1). The subject was helped to define the nature of her problem in simple terms. This usually involved describing how she felt about herself, things which had happened to her, or things which she thought needed to be done in her everyday life. The subject was shown how to rate the 'severity' of the problem at that time. The nurse would ask her: "how distressing do you find this situation?" The 'importance' of the situation was defined by asking her:"how important is it for you to resolve this feeling, or to be able to do this?"

In the early sessions, the subject was helped to define her problems using this format. In the subsequent sessions, she was asked to select

one problem from the 'problem list' for closer attention. The nurse and subject then discussed how she might deal with unpleasant emotions, or face awkward or upsetting situations. During these interactions the nurse tried to stimulate 'solutions', encouraging the subject periodically, and suggesting slight modifications or adaptions. The nurse was required to avoid 'advising' the subject directly. The subject was encouraged to write down some of these ideas in the form of an *aide memoire.*



Problem List	How Severe ?				How Important ?			
CAN'T SLEEP	10				10			
FEEL I'VE LET MY HUSBAND DOWN	9				10			
CAN'T TALK TO ANYONE	8				9			
CAN'T GO OUT	10				10			
FUZZY FEELING IN HEAD	9				10			

NAME EUPHEMIA SMITH ..... DATE 4/1/86 to.....

Figure 14.1 : Example of the 'Problem List', describing fictitious patient and problems, illustrating the first series of ratings of 'severity' and 'importance'.

At the close of the interaction, the subject was encouraged to try using her 'solutions' as an experiment, reporting back to the nurse later that day or the following day.

MCT: *Modified Cognitive Therapy* subjects were approached initially in the same manner described above for the other two groups. In the early sessions, the assessment identifed what the subject saw as her main problems. She was encouraged to document these using the 'problem list' described for the SE group above. All subsequent interactions centred upon the use of a structured care programme which was described in detail in the 'patient's manual' (Appendix 19) : an outline of a six-stage programme 'self-change' programme designed by the author, influenced by the theory and practice of cognitive therapy, as described by Beck *et al.*, 1979) and other psychotherapy theorists.

Theoretical basis of the MCT intervention. The highly didactic nature of the nurse's interaction with MCT group subjects was evocative of Ellis' emphasis in Rational Emotive Therapy (RET) upon an active-didactic approach to helping people detect and dispute the 'irrational demands' which trigger their emotional disturbance (Ellis, 1962). Ellis has also noted that essential ingredients of RET are role-playing situations which involve irrational beliefs, behavioural experiments outwith the therapy session, using imaginative techniques and self-reward (Ellis, 1973). These elements also figured prominently in the MCT intervention.

The emphasis of the MCT intervention upon the 'here and now' was influenced in part by Beck's cognitive therapy, but also owed something to specific ideals inherent in Morita psychotherapy (Reynolds, 1981). This approach to emotional distress, which originated in Japan and is heavily imbued with Eastern attitudes and philosophy, emphasises that 'doing' and 'action' is more important than feelings or thoughts about doing and action. Gibson (1974) recommended the possibility of a fruitful exchange between Morita therapists and behaviour therapists. In this vein Reynolds (1985) has observed that:

> Behaviour is what counts. Not emotion. Not even the results of behaviour. What I do is the only thing in life that I can control. No one can guarantee a life of good feelings. No one can guarantee that our efforts will bring the results we hope for We must be clear on what is controllable (p.18).

In the early stages of the MCT intervention, where the nurse tried to encourage the patient to become more active, or to attend to necessary everyday chores, the nurses encouraged the subject to 'do what *needs* to be done', a phrase borrowed from Moritist writings. In a typically Moritist fashion, the nurse was advised to suggest to the subject that even such activities as 'getting up in the morning, preparing breakfast and talking with someone' are *skills*, which are by no meams trivial. The emphasis upon helping the subject to learn 'how to become more active, by doing what needs to be done' reflects, in part, a Moritist outlook on everyday behaviour.

The core of the MCT intervention was influenced, however, by the work of Beck *et al.* (1980). Some, although not all, the practical suggestions for encouraging the subject to become more active, to gain more self-

reinforcement from her own behaviour and to learn how to identify and challenge discrete thinking errors, were drawn from Beck *et al.* This specific approach to helping patients with affective disorder has been the subject of several research studies, although the author was unable to locate any studies which focussed upon manic depressive subjects. The key research studies, were reported in Chapter 13.

The structure of the MCT intervention. The programme used by the nurse involved specific strategies which focussed upon problems typical of severely depressed people. The areas emphasised are described briefly below. These areas were defined in detail in the 'patient's manual' (Appendix 19), which included specific suggestion as to how the subject might change established patterns of dysfunctional behaviour or thinking. The areas emphasised were :

1. - *increasing activity*: ways of overcoming lethargy and low motivation in order to become more active, and do tasks or chores which were necessary or potentially stimulating.

   - *mastery and pleasure training*: ways of helping the subject become aware of the value of her behaviour, in terms of levels of achievement or enjoyment.

2. - *identifying negative thinking*: helping the subject to understand the possible relationship between her thinking style and her mood. This area also focussed upon helping the subject to 'catch', or attend to, her negative thinking during everyday activity.

3. - *challenging negative thinking*: ways of helping the subject judge the rational value of her own thoughts, and put up alternatives which might have an uplifting effect upon her mood.

4. - *identifying thinking errors*: a catalogue of ten key thinking errors was used to identify dysfunctional thoughts 'used' by the subject.

5. - *experimentation*: ways of planning how to deal with difficult situations in the longer term, by tackling these in an experimental manner.

6. - dealing with setbacks. Learning how to cope with new episodes of depressed affect.

The patient's manual. This intervention was presented in the form of a manual, written and illustrated by the author. A complete copy was provided for the subject's personal use (see Appendix 19) but staff were at liberty to issue selected sections from the manual, recommending these to the subject as 'homework assignments', suggesting that she read certain pages to consolidate work done in the sessions.

Prior to the commencement of the study, the author had used a printed hand-out obtained from the Centre for Cognitive Therapy in Philadelphia as required reading for five patients engaged in psychotherapy on the ward (Beck and Greenberg, 1974). This group reported difficulties in reading and understanding the two page pamphlet. In acknowledgement of the specific motivational and cognitive deficits shown by depressed patients which might interfere with use of such 'supportive

literature', the patient's manual was required to have a 'reading level' equivalent to (or less than) that of a daily newspaper.

The Fog Index (FI) described by Gunning (1952) indicates the number of years of full-time education essential for comfortable reading of a text. A 'quality' national daily newspaper (The Guardian) was found to have an average FI of 16, and a local 'tabloid' newspaper read on the ward (The Evening Telegraph) had an average FI of 10. The FI for Beck and Greenberg's pamphlet was 11.5 (see Appendix 20). The final draft of the patient's manual (Barker, 1983) had an average FI of less than 7 (see Appendix 21).

Visual aids. The initial pages of the manual offered a simple definition of depression and an outline of the conceptual basis of cognitive therapy. The conceptual model of the therapy was illustrated further using a flip-chart which explained the nurse's view that the subject's depression arose, in the main, from her interpretation of events occurring in her life (see Appendix 22). A special script was prepared for the nurse to use in conjunction with the flip-chart. The nurse introduced this visual aid as early in the contact as possible. This judgement was influenced by her assessment of the subject's mood and motivation.

In addition to the manual and the flip-chart, the nurse also used record sheets and visual aids which had been designed specifically to expedite the use of certain techniques employed within the package. Examples of these formats and aids are given in Appendix 23.

In order to simplify further the various stages involved in identifying, rating and monitoring negative thoughts, and learning about 'thinking errors' the flow-chart in Figure 14.2 was used to show subjects the stage they had reached.

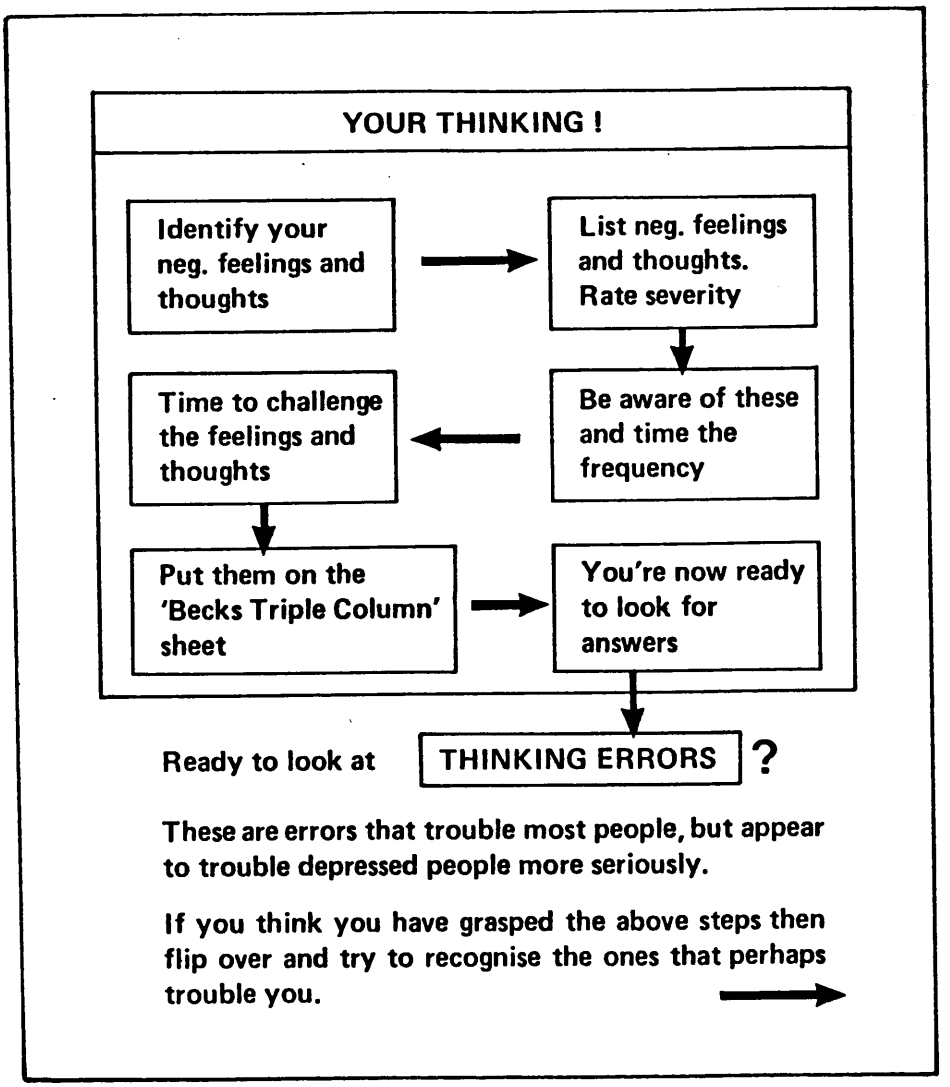


Figure 14.2 : Flow-chart outlining stages involved in dealing with negative thinking.

Time Log. All interactions with the subjects took place on the ward, and involved only one nurse and one subject at any one time. A record of the time spent in each interaction was kept in a 'time log' held in the subject's nursing notes. Nurses were advised to spend no longer than forty minutes per day with each subject, although in some cases this time was divided into two brief sessions held in morning and late afternoon. The time log was maintained to allow an evaluation of the amount of time allocated to subjects within the three group each week.

The research setting

The study was conducted in a fourteen-bed ward in a psychiatric hospital of approximately 550 beds. The ward had a 15-year long association with research into the aetiology and treatment of affective disorder. Although not designated specifically as a female area, the traditional ward population had been almost exclusively female. This situation prevailed during the course of the study. The nursing team had no prior experience of nursing research, but each team member had participated in research led by their medical colleagues. These activities had involved completing ratings on patients participating in drug trials, participating in double-blind drug trials and supervising dietary experiments.

The nursing team. The ward was staffed by two charge nurses, four staff nurses, two enrolled nurses and three nursing assistants. During the first six months of the main (experimental) study, one charge nurse was female and one male. During the final eight months, both charge nurses

were male. One staff nurse was male, all other staff were female. This team was augmented, on average, by two nurse learners who, during the period of the study, were female. This level of staffing was maintained routinely to support the demands of the clinical and medical research programme and was higher than wards of comparable size within the hospital. No special staffing conditions were negotiated as part of the nursing research project.

Prior to commencement, all staff were given a general introduction to the study by the author, supported by the charge nurses. A formal introduction to the aims and methodology of the study, was given later to the trained staff, in the form of a handbook containing a summary of the study, copies of the dependent measures and articles describing the assessment of depression. A shortened summary of the research programme was retained on the ward for the information of new staff joining the team. A copy of this was circulated to the unit Nursing officer and Director of Nursing Services for information.

Staff allocation and training. Staff were allocated to two teams. One team comprised a charge nurse, staff nurse and enrolled nurse: this group worked with one experimental group only (MCT). The second team comprised a charge nurse, three staff nurses and one enrolled nurse and worked with the SE and RNC experimental groups. Due to inter-ward transfers and other changes in personnel, a total of 14 trained staff were involved in the main (experimental) study during its 16-month history.

All staff participating in the study were given training to equip them to carry out the procedures required of their group. Approximately two hours of instruction and discussion was offered to all staff involved in the operation of the experimental groups, at the outset. This related to the methods of data collection, and recording of other information on the subjects. All staff had a working knowledge of the Beck Depression Inventory (BDI) prior to commencement of the study: this measure being used routinely on the ward. They had been involved also in the revision and development of the Patient Satisfaction Scale (PSS). Assessment training focussed, therefore, upon the rationale and administration of the ATQ30, DLCS and DAS.

Staff working with the *Routine Nursing Care* and *Self Evaluation* groups were given approximately three hours of additional instruction and discussion related to running these two groups. Due to staffing constraints, this instruction took place either on an individual or on a small group basis. The team working with the MCT group were offered 10 - 12 hours of instruction in the use of the modified cognitive therapy manual. This instruction was conducted in groups, with the nurses offering examples of experiences from their own lives as content for a mini-workshop. These staff were provided with a short hand-out to read as preparation for the modified cognitive therapy intervention. These notes summarised the main characteristics of the MCT approach and acknowledged the team's possible apprehensions regarding its use (see Appendix 24). Additional short notes were provided to illustrate the use of particular sections of the manual (see Appendix 25). All training and discussion was led by the author.

CHAPTER 15

RESULTS OF THE MAIN (EXPERIMENTAL) STUDY

Overview of results. This chapter presents the results of the main (experimental) study in four sections. In section A, all 30 subjects, who completed the study are described at the six-month follow-up after discharge. In section B, a data analysis is presented of the four measures of dependent variables (*depression, negative automatic thoughts, dysfunctional beliefs and locus of control*) which were assumed to be significant characteristics of affective disorder. In section C, a data analysis is presented of the measure of the fifth dependent variable, *satisfaction wih care and treatment*, and section D presents an analysis of the uncontrolled variables, length of hospital stay and drug treatment.

A : *Outcome at Follow-Up*

A decision was taken in advance of the implementation of the main (experimental) study to follow up the subjects six months after discharge. Although it was recognised that a follow up conducted over a longer period, such as one year, would provide a more reliable measure of treatment outcome, six months was identified as an acceptable minimum period for a follow up evaluation (Naylor, 1984).

A total of 30 subjects completed the admission and discharge ratings and agreed to continue contact with the project up to, and including, a six-month follow up at home. These 30 subjects were evenly distributed

across the three experimental groups, with ten subjects each in the Routine Nursing Care (RNC), Self Evaluation (SE) and Modified Cognitive Therapy (MCT) groups.

Five subjects were readmitted within this six-month period. All five returned, at least temporarily, to the ward on which the study was based. Three of these readmitted subjects belonged to the *Routine Nursing Care* group and two were from the *Self Evaluation* group. No subjects from the *Modified Cognitive Therapy* group were readmitted within the six-month follow-up period.

Complete follow-up data were not collected on the five subjects who relapsed. In the description of the data from the Automatic Thoughts Questionnaire (ATQ30), the Dysfunctional Attitude Scale (DAS) and the Depression Locus of Control Scale (DLCS) which follows, follow-up scores for the readmitted subjects are represented by the subjects' admission *or* discharge scores whichever was, clinically, the better score, in an attempt to make between-group comparisons more stringent. As noted above, this procedure was applied, therefore, only in the case of the three readmitted subjects from the Routine Nursing Care (RNC) group and the two readmitted subjects from the Self Evaluation (SE) group.

Routine screening of all admissions to the ward included completion of the Beck Depression Inventory (BDI). The follow-up scores for the readmitted subjects on the BDI are represented, therefore, by their readmission score.

B : Analysis of the Measures of Dependent Variables Characteristic of Affective Disorder

1. Dependent variable 1 : depression

This variable was measured by the *Beck Depression Inventory* (BDI). Depression scores for each subject were calculated on the BDI on admission, at discharge and at follow-up. Two hypotheses were stated in relation to this dependent variable:

Null Hypothesis 1. Measures of depression on the BDI will not differ significantly between the groups RNC, SE and MCT at discharge.
Research Hypothesis 1. The MCT group will yield lower BDI scores than RNC or SE, at discharge.

Null Hypothesis 2. Measures of depression on the BDI will not differ significantly between the groups RNC, SE and MCT, at follow-up.
Research Hypothesis 2. The MCT group will yield lower BDI scores than RNC or SE, at follow-up.

Overview of the BDI data. Means and standard deviations for the three experimental groups (RNC, SE and MCT) are shown in Table 15.1. Group means and the dispersion of raw scores were similar for the three groups on admission. The original report by Beck *et al.* (1961) describing the development and validation of the BDI, reported the following categories of depression from their sample: 'non-depressed' ($\bar{X}$=10.9), 'mild' ($\bar{X}$=18.7), 'moderate' ($\bar{X}$=25.4) and 'severe' depression

($\bar{X}$=30.0). These mean scores are commonly referred to as 'cut-off points'.

Table 15:1 Means, Range and Standard Deviations for the BDI.

Group	*Admission*	*Discharge*	*Follow-up*
SE $\bar{X}$ (SD)	35.0 (12.3)	20.8 (5.9)	16.8 (10.7)
Range	19 - 54	*11 - 28*	*2 - 35*
RNC $\bar{X}$ (SD)	36.3 (14.7)	16.6 (6.8)	19.0 (16.1)
Range	18 - 56	4 - 24	0 - 46
MCT $\bar{X}$ (SD)	33.9 (10.3)	16.6 (5.9)	6.8 (6.1)
Range	19 - 53	10 - 26	0 - 19

Key: *SE* : Self Evaluation
RNC: Routine Nursing Care
MCT: Modified Cognitive Therapy

Slightly different normative cut-off points have been reported for the revised version of the BDI used in the main (experimental) study, which has been reported by Beck *et al.* (1980). Burns (1980) reported the following norms for the revised BDI:

Total Score	*Level of Depression*
1 - 10	Normal ups and downs.
11 - 16	Mild mood disturbance.
17 - 20	Borderline clinical depression.
21 - 30	Moderate depression.
30 - 40	Severe depression.
over 40	Extreme depression.

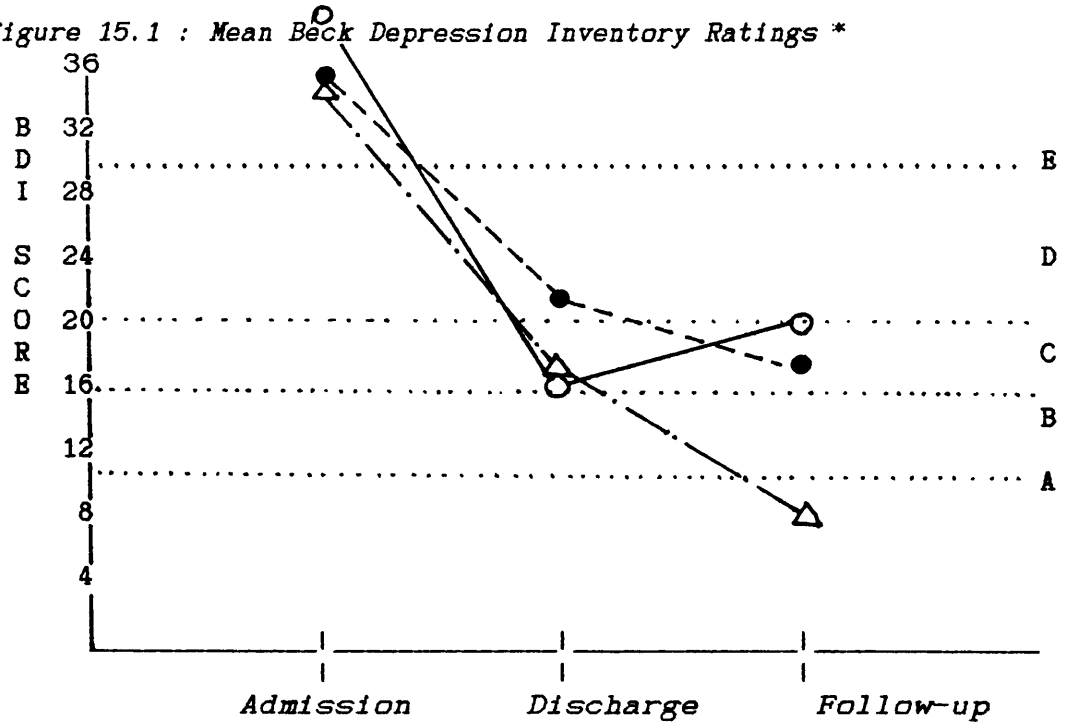
Table 15.1 shows that mean admission scores for each group fell within the '*severe* depression' category reported by Burns (1980). Individual scores across the three groups, ranged from 'moderate depression' to 'extreme depression'. Scores for all 30 subjects were reduced at

discharge. Mean scores for the RNC and MCT groups were below the cut-off point for 'borderline clinical depression' (<17). The SE group mean was within this 'borderline clinical depression' range. At the six month follow-up, the SE and MCT groups maintained an overall reduction in mean scores. The *MCT* group mean fell within the range of 'normal ups-and-downs', with the SE mean below the 'borderline depression' cut-off point. The average *RNC* score, however, showed a slight rise to within the range of clinical depression. A graphic representation of the trend of these group means, in relation to the Burns' level of depression cut-off points, is shown in Figure 15.1.

Between-groups analysis

Null hypotheses 1 and 2, predicted that there would be no difference between the BDI scores of the three groups, on discharge (1) and at follow-up (2). **Research hypotheses** 1 and 2, predicted that the MCT group would yield lower BDI scores than either of the other two groups, on discharge (1) and at follow-up (2). Given that three independent groups were under study, a test for *k* independent samples was required to test for *between-group* differences. The data produced by the BDI represented ordinal measurements, therefore the nonparametric, Kruskal-Wallis One-Way Analysis of Variance by Ranks (Seigel, 1956), was appropriate. The significance level was set at .05.

*Figure 15.1 : Mean Beck Depression Inventory Ratings **



Key: A = <11 'non-depressed'
B = 11 - 16 'mild mood disturbance'
C = 17 - 20 'borderline clinical depression'
D = 21 - 30 'moderate depression'
E = 30 - 40 'severe depression'

Routine Nursing Care
Self Evaluation
Modified Cog. Therapy

* The author acknowledges that these data points are not continuous. The mean scores are represented here in graph form merely as an aid towards clarification of the trend of the group means.

All ratings were ranked together in a single series. Ranks for each group were added to produce a rank total for each experimental condition. If no significant difference existed between the groups (the null hypothesis) high and low ranks would be expected to be spread, roughly equally, among the three conditions. The Kruskal-Wallis test determines whether the sums of the ranks are so disparate that they are unlikely to have come from samples drawn from the same population.

Analysis of admission scores showed no significant difference between the groups (H=0.01, df=2, *ns*). The same one-way analysis of variance compared the subjects' scores at discharge and follow-up.

Hypothesis 1. At *discharge* no significant difference between the three groups (Routine Nursing Care, Self Evaluation and Modified Cognitive Therapy) was evident (H=3.05, df=2, *ns*).

Hypothesis 2. At *follow-up* the difference in scores between the three groups passed the significance level (H=6.33, df=2, p<0.04).

Multiple comparisons. The Kruskal-Wallis test showed an overall difference between the scores of the three groups at follow-up. The study hypothesised that the *MCT* subjects would show greater changes than subjects in the other two groups. To test this further, *a posteriori* comparison was made of pairs of groups, using the Mann-Whitney U test (Seigel, 1956). It is commonly accepted that posteriori comparisons are appropriate only where sigificant differences between groups have been demonstrated. However, to clarify the between groups analysis described above, pairs of groups at each stage of the study (admission, discharge *and* follow-up) were compared.

Since the BDI involved ordinal measurements, a nonparametric test was required. The Mann-Whitney U test is the appropriate nonparametric test for a two condition, unrelated design, where different subjects are used for each condition. Ratings for all subjects were ranked in a single series after which rank totals were calculated for each group.

The Mann-Whitney test determines whether two groups have been drawn from the same population. Seigel (1956) suggests that this is one of the most powerful of the nonparametric tests and is a useful alternative to the parametric *t* test where "measurement is weaker than interval scaling (p.116)". Since the research hypotheses 1 and 2 were *unidirectional*, predicting that the MCT group would yield lower scores than either of the other two groups on discharge and at follow-up, comparsions between MCT and the other groups at these points involved one-tailed tests, with significance level set at .025. All other comparisons involved two-tailed tests, significance level set at .05.

No significant difference existed on admission between *SE* and *RNC* (U=49, *ns: two-tailed test*) or between *RNC* and *MCT* (U=47.5, *ns : two-tailed test), or at discharge between SE* and *MCT* (U=31.5, *ns: one-tailed test*) or *MCT* and *RNC* (U=47, *ns; one-tailed test*). At follow-up, significant differences were found between *MCT* and the other two groups: *MCT* and *RNC* (U=23.5, $p<0.025$: one-tailed test); *MCT* and *SE* (U=19.5, $p<0.01$: one-tailed test).

Within-group analysis : A. The Kruskal-Wallis test evaluated overall differences between subjects' scores in the three groups, at each stage of the study. To clarify whether changes had occurred in BDI scores *within groups* across the stages of the study, two further analyses were undertaken. In the first analysis, the BDI scores of each group, on admission, at discharge and at follow-up, were compared. Since these three sets of scores were drawn from the same group, representing a related design, and the data represented ordinal measurements,

Friedman's Two-Way Analysis of Variance by Ranks (Seigel, 1956) was selected as the appropriate nonparametric test for a *related* design. Significance level was set at .05.

Each subject's ratings were ranked horizontally across the three conditions (admission, discharge and follow-up) for each experimental group. Rank totals were calculated by adding the ranks within each condition. If no significant difference existed between the three samples (the null hypothesis), high and low ranks would be expected to be spread, roughly equally, among the three conditions. The Freidman test determined whether it was likely that the different columns of ranks (samples) came from the same populations.

Although mean scores for the the *Self Evaluation* group showed a downward trend across time, this was not statistically significant (χ_r^2=13.05, df=9, *ns*). Despite the slight rise in mean scores at follow-up, individual scores in the the *Routine Nursing Care* group showed a statistically significant change across the three phases of the study (χ_r^2=17.73, df=9, p<0.038). The steady downward trend in the mean scores of the *Modified Cognitive Therapy*, noted earlier, also passed significance level (χ_r^2=18.16. df=9, p<0.033).

Within-group analysis : B. The Freidman test showed that although the RNC and MCT groups BDI scores changed significantly *across the three phases of the study*, no significant change occurred in the case of the SE group. To test whether BDI scores at follow-up showed a positive change, in terms of reduced ATQ30 scores over admission, a second

within-groups analysis was undertaken. Since this analysis involved a two sample, related design, using ordinal measurments, the Wilcoxon Signed-Ranks Test (Seigel, 1956) was selected as the appropriate nonparametric test.

Follow-up ratings were subtracted from admission ratings. The differences were ranked in order of magnitude. Plus and minus ranks were added to provide two seperate rank totals for each group. The *smaller* of these rank totals was used in the computation of the significance level which was set at .025 for a one-tailed test.

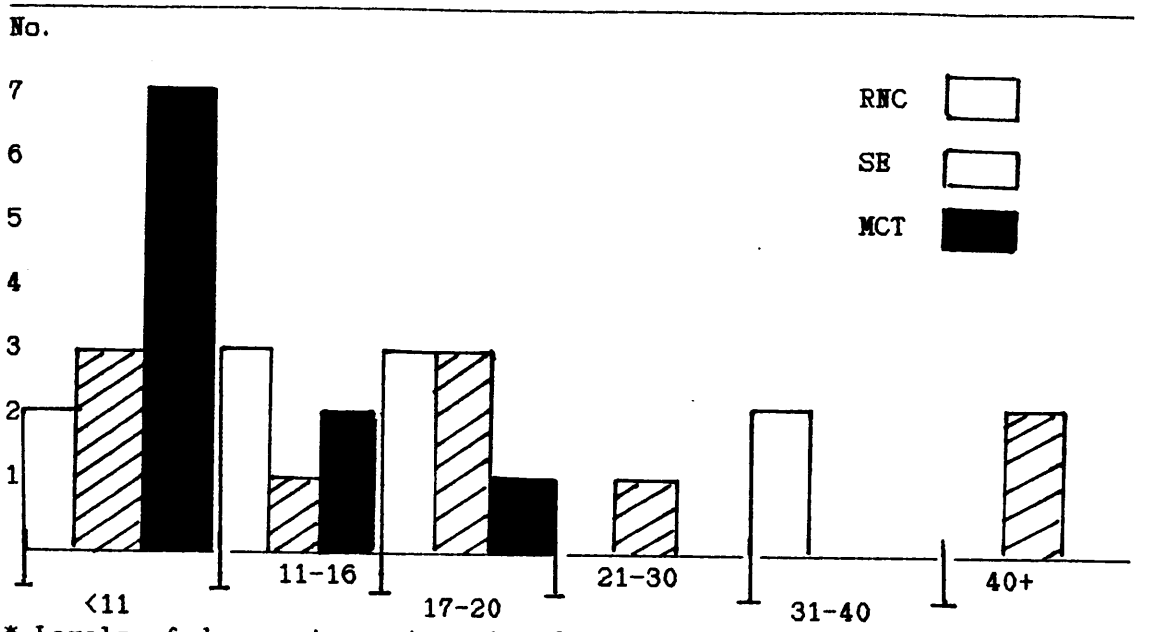
A comparison of admission and follow-up BDI ratings showed significant changes for all three groups ($T=0$, $N=10$, $p<0.005$).

The measurement of clinically significant change

Although statistically significant changes were shown for all three groups between admission and follow-up, this does not show whether such changes were of *clinical* significance. All follow-up scores were classified in terms of Beck's levels of depression (see Figure 15.2).

Four RNC subjects scored *below* the level of 'borderline clinical depression', one of these was in the 'mild mood disturbance range and three in the 'normal' range. Three scores fell within the 'borderline' range (17 - 20), one score was within the 'moderate depression' range, and two were within the 'extreme depression' range (40+).

Figure 15.2: *Levels of Depression at Six-Month Follow-up**



* Levels of depression categories drawn from Burns, 1980.

Five SE subjects scored below the level of 'borderline clinical depression', two of these were in the 'normal' range and three in the 'mild mood disturbance' range. Three subjects were within the 'borderline depression' range and two scored within the 'severe depression' range.

Nine MCT subjects scored below the level of 'borderline clinical depression', two subjects fell within the 'mild mood disturbance' category and seven within the 'normal' range. One subject scored within the 'borderline clinical depression' range.

At this level of analysis almost two thirds of the subjects' scores at follow-up fell below the cut-off point for 'borderline clinical depression'. The difference between individual subject's admission and

follow-up scores was calculated using the Christensen and Mendoza's SC index (see Table 15.2). Christensen and Mendoza's formula described a change of greater than one standard deviation (±1.96) as a significant change. Using this formula, three *Self Evaluation*, five *Routine Nursing Care* and all ten *Modified Cognitive Therapy* subjects made a significant clinical change during the study's three stages.

Table 15.2 : BDI - SC index scores (after Christensen & Mendoza, 1986)

	RNC			*SE*			*MCT*	
1.	-3.5	*	1.	-8.11	*	1.	-4.61	*
2.	-6.04	*	2.	-1.27		2.	-3.81	*
3.	-0.15		3.	-1.90		3.	-2.70	*
4.	-0.48		4.	-7.95	*	4.	-3.34	*
5.	-5.09	*	5	-1.75		5.	-3.5	*
6.	-2.7	*	6.	-1.11		6.	-7.8	*
7.	-1.11		7.	-0.63		7.	-11.61	*
8.	-1.59		8.	-1.11		8.	-3.02	*
9.	-0.79		9.	-3.18	*	9.	-3.18	*
10.	-6.04	*	10.	-1.91		10.	-5.41	*

* = p<0.05

A comparison of these SC index scores, employing Kruskal Wallis One Way Analysis of Variance, showed no significant difference between the groups (H=5.14, df=2, *ns*). A further comparison of the SC index scores was made, between those who were 'significantly changed' on this index, and those who were not, using the Chi-Square test. This showed a significant difference between the number of subjects who had, or had not, made a 'significant change' on the Christensen and Mendoza index, within the three groups (x^2 = 10.87, *df* =2, p< .01). It should be noted, however, that Cochran (1954) recommended that for x^2 tests where *k* is larger than 2, fewer than 20 per cent of the cells should have an

expected frequency of less than 5, and no cell should have an expected frequency of less than 1 (cited by Seigel, 1956: p.178). In this analysis of the SC index scores, three of the six cells (50%) had expected frequencies of only 4.

2. Dependent variable 2 : negative automatic thoughts

This variable was measured by the *Automatic Thoughts Questionnaire (ATQ30)*. The subject's reported use of specific forms of negative automatic thoughts was assessed on admission, at discharge and at follow-up by the ATQ30. Minimum and maximum scores on this scale were 30 and 150 respectively.

Null Hypothesis 3. Measures of negative automatic thoughts on the ATQ30 will not differ significantly between the three groups, RNC, SE and MCT, at discharge.

Research Hypothesis 3. The MCT group will yield lower scores on the ATQ30 than RNC or SE at discharge.

Null Hypothesis 4. Measures of negative automatic thoughts on the ATQ30 will not differ significantly between the three groups RNC, SE and MCT, at follow-up.

Research Hypothesis 4. The MCT group will yield lower scores on the ATQ30 than RNC or SE at follow-up.

Overview of the ATQ30 data. Means, score range and standard deviations for each group across the three phases are shown in Table 15.3. On admission, mean scores for Self Evaluation and Routine Nursing Care

were similar, both slightly higher than Modified Cognitive Therapy subjects. At discharge, all three groups showed a decrease in the mean scores which was maintained on follow-up.

Table 15.3 : Means, Range and Standard Deviations for the ATQ30

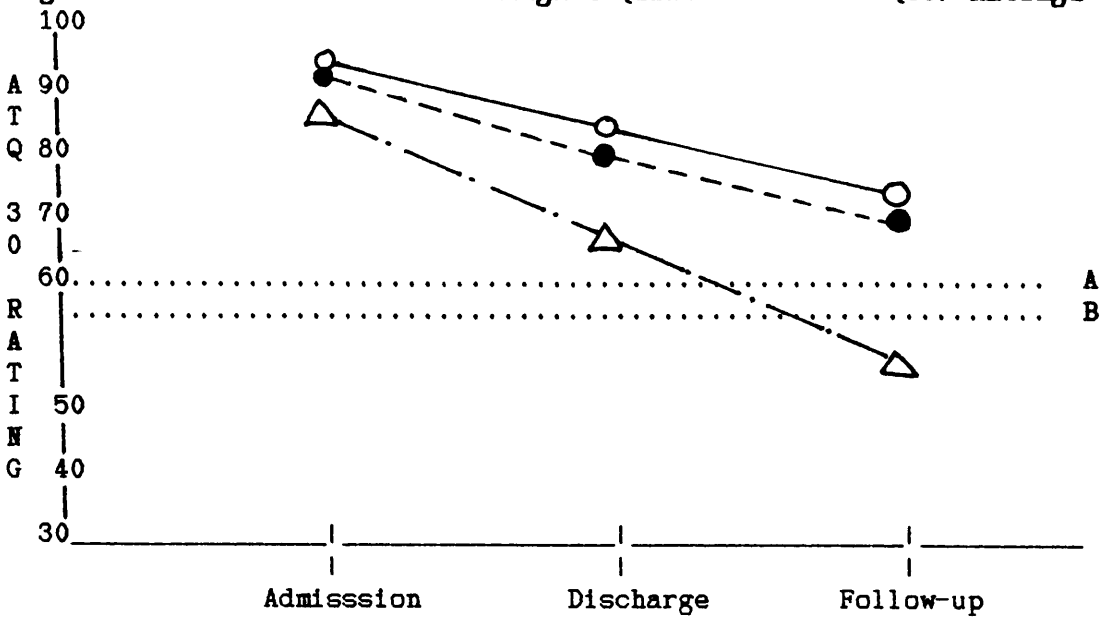
Group		Admission	Discharge	Follow-up
SE	$\bar{X}$ (SD)	100.2 (27.0)	90.2 (34.4)	76.5 (25.5)
	Range	55 - 150	31 - 150	33 - 101
RNC	$\bar{X}$ (SD)	103.5 (19.7)	92.8 (27.4)	81.3 (30.4)
	Range	67 - 141	45 - 135	35 - 130
MCT	$\bar{X}$ (SD)	92.0 (25.0	74.2 (32.3)	55.1 (24.0)
	Range	53 - 131	30 - 146	30 - 94

Key : SE : Self Evaluation
RNC: Routine Nursing Care
MCT: Modified Cognitive Therapy

The original undergraduate sample of Hollon and Kendall (1980) provided a mean of 79.64 (SD = 22.29) for *depressed* (n= 14) and 48.57 (SD = 10.89) for *non-depressed* subjects (n= 21). In view of the small sample of non-depressed subjects, all of whom were university students, used in Hollon and Kendall's original study, another female sample (n = 107) was drawn from the catchment area of the main (experimental) study to provide further normative comparison. This sample, which was described in Chapter 14, provided scores which were similar to Hollon and Kendall's non-depressed group: mean = 41.94 (SD = 11.89).

The mean group ratings for each of the three experimental groups are presented graphically in Figure 15.3.

Figure 15.3 : Mean Automatic Thoughts Questionnaire (ATQ30) Ratings'



Key : Routine Nursing Care ∘———∘
Self Evaluation ∘- - -∘ A = Non-depressed cut-off (59.5)*
Mod. Cog. Therapy Δ—·—Δ B = Non-depressed cut-off (53.8)**

Cut-of scores based upon data from the studies of * Hollon & Kendall (1980) and ** Barker (1984): both one S.D. *above* the mean.

' The author acknowledges that these data points are not continuous. The mean ratings are presented here in graph form merely as an aid to clarification of the trend of the group means.

Admission and discharge means for all three groups placed them within the 'depressed' range described by Hollon and Kendall (1980). At the six-month follow-up, the RNC and SE groups maintained an overall reduction in their mean scores, but still scored within the depressed range. The MCT group mean score, however, was within the 'normal' range reported by Hollon & Kendall (1980) but remained higher than the normal range reported by Barker (1984).

Between groups analysis

Null hypotheses 3 and 4 predicted that there would be no difference between the ATQ30 scores of the three groups, on discharge (3) and at follow up (4). **Research hypotheses** 3 and 4 predicted that the MCT group would yield lower ATQ30 scores than either of the other two groups (RNC and SE). Given that three independent groups were under study, a test for *k* independent samples was required to test for between-groups differences. The data produced by the ATQ30 represented ordinal measurements, therefore the nonparametric, Kruskal-Wallis One-Way Analysis of Variance by Ranks was considered the appropriate test. The significance level was set at .05.

Analysis of admission scores showed no significant differences between the three groups (H = 0.839, df=2, *ns*). The same one-way analysis of variance compared the scores of the three groups at discharge and follow up.

Hypothesis 3. At discharge, no significant difference existed between the three groups at the 5 per cent level (H = 2.565, df=2, *ns*).

Hypothesis 4. At follow-up, no significant difference existed between the three groups at the 5 per cent level (H = 5.357, df=2, *ns*).

Multiple comparisons. The research hypotheses stated that the MCT group would show lower scores at discharge and follow up, than either of the other two groups. The Kruskal Wallis test showed no significant differences between the three groups, at any stage in the study,

admission, discharge or follow-up. Although it is not usually appropriate to conduct paired comparisons in the absence of significant between-group differences, this was undertaken to clarify further the between-groups analysis described above.

The ratings of pairs of groups, on admission, at discharge and at follow-up, were analysed using the Mann-Whitney U Test (Seigel, 1956). Given that the ATQ30 involved ordinal measurements, a nonparametric test was considered appropriate. The Mann-Whitney U Test was the appropriate test for a two-condition, unrelated design, where different subjects are used for each condition. Since the research hypotheses 3 and 4 were *unidirectional*, predicting that the MCT group would yield lower ATQ30 scores than either of the other two groups at discharge and follow-up only, comparisons between MCT and the other two groups at these points involved one-tailed tests, with the significance level set at .025. All other comparisons involved two-tailed tests, with the significance level set at .05.

No significant differences existed between SE and MCT (U=47, *ns: two-tailed*) or RNC and MCT (U=38, *ns: two-tailed*) on admission, or on discharge : MCT and SE (U=33, *ns: one-tailed*), MCT and RNC (U=31, *ns: one-tailed*) At follow-up, MCT group scores were significantly lower than those of the RNC group: MCT and RNC (U=23, $p<0.025$: one-tailed). However, the difference between MCT and SE failed to reach the significance level MCT and SE (U=25, $p<0.03$: one-tailed).

Within groups analysis: A. The Kruskal-Wallis test evaluated overall differences between subjects' scores on the ATQ30 in the three groups, at each stage of the study. The mean scores for each group reported above showed a gradual decrease across the three phases. To clarify whether significant changes had occurred *within* groups across the three stages of the study two further analyses were undertaken. In the first analysis, the ATQ30 scores of each group, on admission, at discharge and at follow up, were compared. Since these three sets of scores were drawn from the same group, representing a related design, and the data represented ordinal measurements, Friedman's Two-Way Analysis of Variance by Ranks, was selected as the appropriate nonparametric test for a related design. Significance level was set at .05.

The changes in ATQ30 scores, across the three stages of the study (admission, discharge and follow up), were statistically significant for all three groups : *SE* (χ_r^2=18.58, df=9, p<0.03); *RNC* (χ_r^2=21.85, df=9, p<0.01) and *MCT* (χ_r^2=22.47, df=9, p<0.008).

Within groups analysis : B. To test whether the ATQ30 scores of the three groups showed a *positive* change between admission and follow up (that is, showed *lower* scores at follow up, over admission) a second within-groups analysis was undertaken. Since this involved a two-sample, related design, using ordinal measurements, the Wilcoxon Matched-Pairs Signed-Ranks Test (Seigel, 1956), was selected as the appropriate nonparametric test. Since the alternative hypothesis predicted a *positive* change in ATQ30 scores (unidirectional) a one-tailed test was employed, with significance set at the .025 level.

A comparison of admission and follow-up ratings on the ATQ30 showed statistically significant changes within all three groups (T=0, N=10, $p<0.005$).

The measurement of clinically significant change

Although statistically significant changes across the three stages of the study, and between admission and follow-up, were demonstrated for all three groups, this does not show whether such changes were of clinical significance.

On admission, the majority of subjects in each group scored 70+: at or beyond the mean level of the depressed sample in Hollon and Kendall's (1980) study. At follow-up, more than half of the subjects in the Self Evaluation and Routine Nursing Care groups scored 70 or more, whereas the majority of the Modified Cognitive Therapy subjects scored below this level.

Figures 15.4, 15.5 and 15.6, shown overleaf, describe the distribution *of Automatic Thoughts Questionnaire* scores for each group, comparing the distribution of scores on admission and at follow-up. Each group comprised ten subjecs.

Figure 15.4 : Distribution of ATQ30 Scores - SE Group

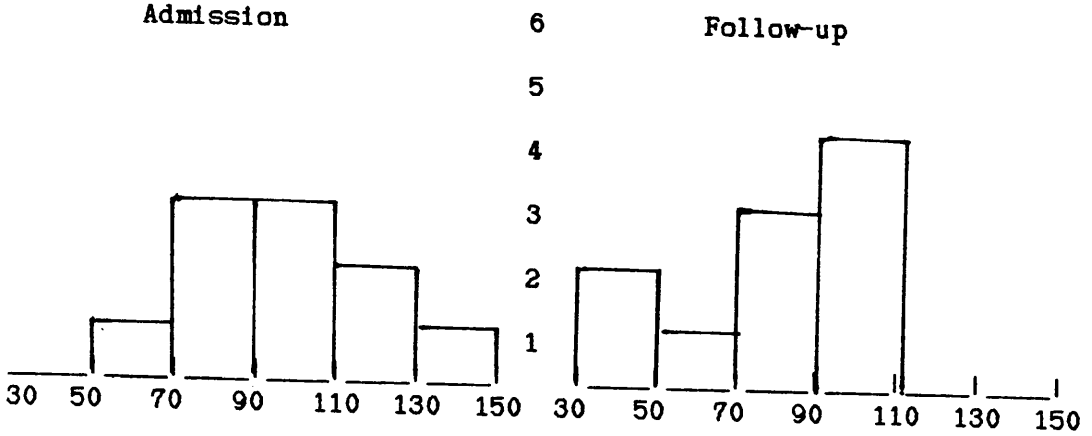


Figure 15.5 : Distribution of ATQ30 Scores - RNC Group

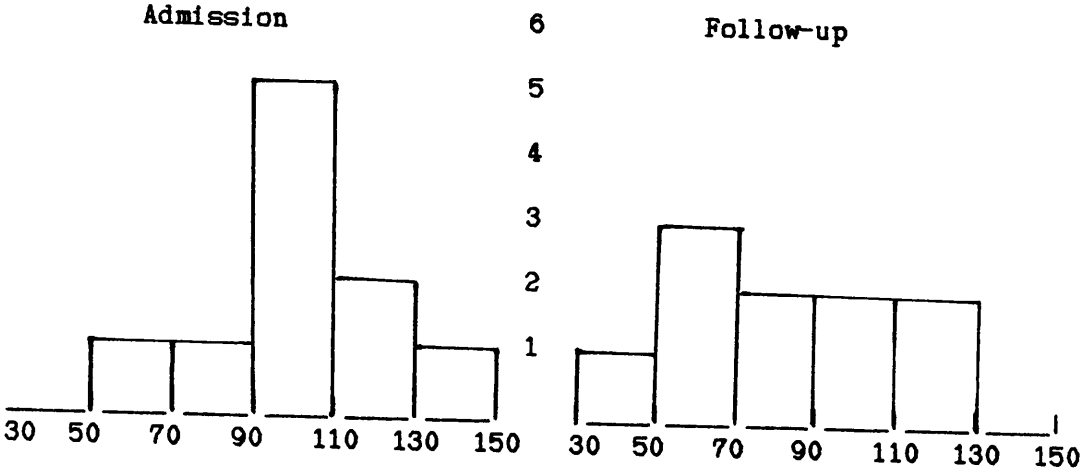
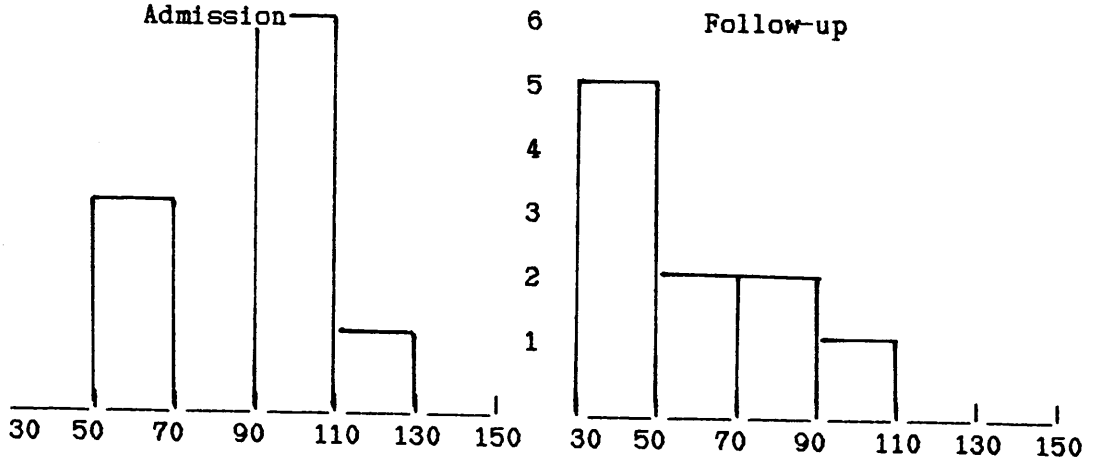


Figure 15.6 : Distribution of ATQ30 Scores - MCT Group



Admission and follow-up ratings were compared for each of the three groups using Christensen and Mendoza's *significant change index* (SC). The SC index scores are presented in Table 15.4.

Table 15.4 : ATQ30 - SC Index Scores (after Christensen & Mendoza, 1986).

	RNC	SE	MCT
1.	-2.62 *▲	-2.77 *▲	-9.09 *▲
2.	-6.16 *	0.0	-9.97 *▲
3.	0.0	-1.39	-0.15 ▲
4.	-3.24 *	-18.02 *▲	-2.92 *
5.	-1.69	-2.92 *	-5.39 *
6.	-3.54 *	0.0	-5.70 *
7.	0.0	-4.93 *	-9.40 *▲
8.	0.0	0.0	-4.90 *▲
9.	-9.09 *▲	-3.69 *	-3.54 *▲
10.	-7.86 *▲	-2.46 *	-6.01 *

* = $p<0.05$

▲ = scores which moved from beyond to below the cut-off (<53.8)

Using the SC formula, six subjects from the SE and RNC groups achieved a significant clinical change during the study. Nine of the ten MCT

subjects showed significant changes at beyond Christensen and Mendoza's 0.05 level.

Using the data from the author's own normative sample, a cut-off point was established at 53.8: one standard deviation above the mean. Using this criterion, the scores of two subjects from the SE group, three from the RNC and six from the MCT group scored moved from beyond to within the range of the normative sample.

A comparison of these SC index scores using the Kruskal Wallis One Way Analysis of Variance showed no significant difference between the groups (H=5.13, df=2, *ns*). A further comparison of the SC index scores was made, between those who were 'significantly changed' on this index and those who were not. Using the Chi-Square Test, no significant difference was found between those who were, or were not, 'significantly changed' within the three groups (χ^2=2.84, *df*=2, *ns*). It should be noted, however that, as in the analysis of the SC index scores drawn from the Beck Depression Inventory described earlier, three of the six cells (50%) in the Chi-Square had expected frequencies of less than 5. The significance of this finding needs to be judged with this in mind.

3. Dependent variable 3 : dysfunctional beliefs

This variable was measured by use of Burns' (1980) shortened Dysfunctional Attitude Scale (DAS). The scale was administered on admission, at discharge and at follow-up. Two hypotheses were stated in relation to this variable:

Null Hypothesis 5. Measures of dysfunctional beliefs on the DAS will not differ significantly between the three groups RNC, SE and MCT, at discharge.

Research Hypothesis 5. The MCT group will yield higher DAS scores than RNC or SE at discharge.

Null Hypothesis 6. Measures of dysfunctional beliefs on the DAS will not differ significantly between the three groups RNC, SE and MCT at follow up.

Research Hypothesis 6. The MCT group will yield higher DAS scores than RNC or SE at follow-up.

Overview of the DAS Data. Means, score range and standard deviations for the three groups (Routine Nursing Care [RNC], Self Evaluation [SE] and Modified Cognitive Therapy [MCT]) are shown in Table 15.5. Group means were similar for all three groups on admission. However, the scores of subjects in the SE and MCT groups were much more widely dispersed than those of the RNC subjects. This may be accounted for by the differences in the score ranges of the three groups. The RNC group's score range was lowest at 32, with SE at 48. The score range

for the MCT group was, at 97, much greater than either of the other two groups.

Table 15.5 : Means, Range and Standard Deviations for the DAS

Group		Admission	Discharge	Follow-Up
SE	$\bar{X}$ (SD)	84.1 (16.1)	89.1 (27.1)	90.5 (22.1)
	Range	54 - 102	37 - 138	57 - 124
RNC	$\bar{X}$ (SD)	70.2 (9.5)	71.9 (19.0)	84.2 (16.9)
	Range	60 - 92	38 - 103	60 - 117
MCT	$\bar{X}$ (SD)	86.7 (32.0)	93.0 (37.8)	104.9 (34.5)
	Range	36 - 133	42 - 172	48 - 173

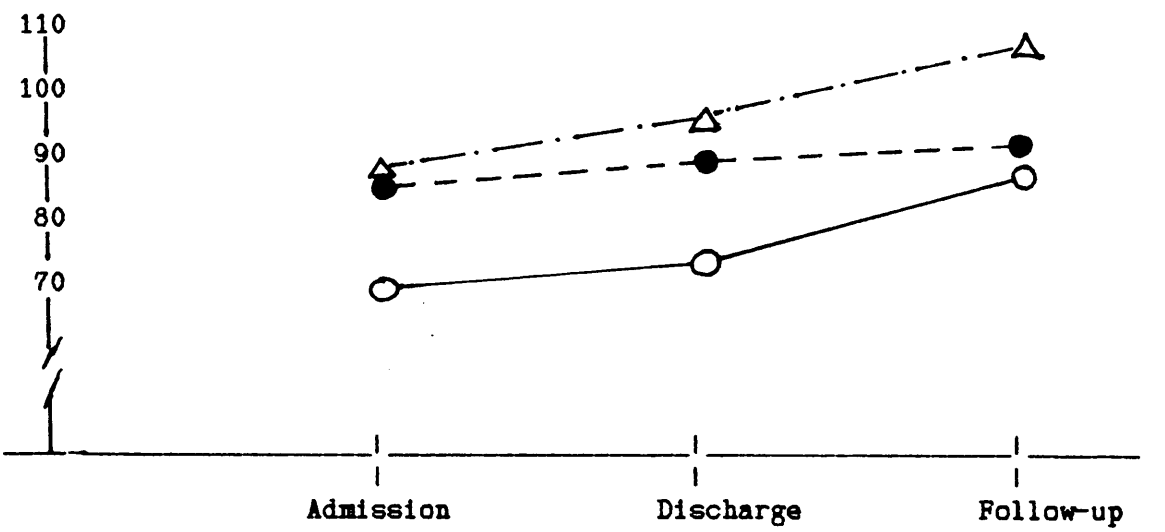
Key : SE : Self Evaluation
RNC : Routine Nursing Care
MCT : Modified Cognitive Therapy

Norms have not been reported for Burns' (1980) version of the DAS used here, although recent studies have described the use of this shortened scale (Durham and Turvey, 1987). In the absence of normative data, a sample of women from the catchment area of the study was drawn by the author to serve as a normative comparison group. The details of this sample were described in Chapter 14. The mean for this sample (n=124) was 116.8 (SD = 18.6).

The possible range of scores on the DAS was from 35 - 175: the scale assumed that lower scores indicated the presence of more dysfunctional beliefs. The higher the subject's score, the less she was assumed to suffer from dysfunctional beliefs. Mean scores for the SE and MCT groups were similar on admission with the RNC group's mean score

approximately fifteen points lower, suggesting that RNC group subjects exhibited more dysfunctional beliefs. These mean values were lower than the mean of the normative group reported, suggesting that all three experimental group scores showed more dysfunctional beliefs than the women in the normative sample. At discharge, small mean gains were evident for the SE and MCT groups although the dispersion of scores had increased for all three groups. At follow-up, the mean SE score showed little change, whereas the RNC and MCT means showed most change during this period. At follow-up, the mean MCT score was within the normal limits of the normative sample: the other two experimental group means remained outwith these limits. The trend of these group means is shown in Figure 15.7.

Figure 15.7 : Mean ratings for the DAS [1]



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[1] The author acknowledges that these data points are not continuous. The mean scores are represented here in graph form merely as an aid towards clarification of the trend of the group means.

Between-groups analysis

Null hypotheses 5 and 6 predicted that there would be no difference between the DAS scores of the three groups on discharge (5) and at follow up (6). Research hypotheses 5 and 6 predicted that the MCT group would yield higher DAS scores than either of the other two groups, on discharge (5) and at follow up (6). Given that three independent groups were under study, a test for *k independent samples was required to test for between-groups* differences. As the data produced by the DAS represented ordinal measurements, Kruskal-Wallis One-Way Analysis of Variance by Ranks, was selected as the appropriate nonparametric test. The significance level was set at .05.

Analysis of admission scores showed no significant difference between (H=3.28, df = 2, *ns*). The same, one-way analysis of variance compared the subjects' scores at discharge and follow-up.

Hypothesis 5. At discharge, no significant difference was evident between the three groups (H=3.70, df = 2, *ns*).

Hypothesis 6. At follow-up, no significant difference was evident between the three groups (H=3.23, df = 2, *ns*).

Multiple comparisons. The research hypotheses stated that MCT subjects' DAS scores, would show a greater positive change than either of the other two groups, at discharge and at follow up. Although it is not entirely appropriate to conduct paired comparisons in the absence of significant *between-group* differences, this was undertaken to clarify

further the between-groups analysis described above. Pairs of groups, on admission, at discharge and at follow-up were analysed. Since the DAS involved ordinal measurements, a nonparametric test was required. The Mann-Whitney U test is the appropriate nonparametric test for a two condition, unrelated design, where different subjects are used for each condition. Since the research hypotheses 5 and 6 were *unidirectional*, predicting that the MCT group would yield higher scores than either of the other two groups, at discharge and at follow-up, comparisons between the MCT and other groups at these points involved one-tailed tests, with the significance level set at .025. All other comparisons involved two-tailed tests.

No significant difference existed on admission between RNC and SE (U=25.5, *ns: two-tailed*) or RNC and MCT (U=33.5, *ns*: two-tailed). At discharge, the similarites between the groups were maintained: RNC and SE (U=25.5, *ns: two-tailed*), RNC and MCT (U=30, *ns*: one tailed). At follow-up, no significant difference was evident between RNC and SE (U=40, *ns: two-tailed*) orMCT and RNC (U=26.5, ns: one-tailed).

Within groups analysis: A. To clarify whether changes had occurred in DAS scores *within groups* across the three stages of the study, two further analyses were undertaken. In the first analysis, the DAS scores of each group on admission, at discharge and at follow-up were compared. Since these three sets of scores were drawn from the same group, representing a related design, and the data represented ordinal measurements, Friedman's Two-Way Analysis of Variance by Ranks (Seigel,

1956) was employed as the appropriate nonparametric test for a related design. Significance level was set at .05.

Although an overall change occurred in mean of the Routine Nursing Care group scores, this did not reach significance level (χ_r^2=14.27, df = 9, *ns*). Changes across time were significant for the Self Evaluation group (χ_r^2=22.71, df = 9, p<0.007) and for the Modified Cognitive Therapy group (χ_r^2=25.91, df = 9, p<0.002).

Within-group analysis : B. To test whether the DAS scores at follow-up showed a positive change, compared with admission, a second within-groups analysis was undertaken. Since this involved a two sample, related design, using ordinal measurements, the Wilcoxon Matched-Pairs Signed Ranks Test, was employed as the appropriate nonparametric test. Since the research hypothesis predicted a positive change in DAS scores a one-tailed test was used. Significance was set at .025.

No significant difference was found between the admission and follow-up scores of the SE subjects (T=16, n=10, *ns*), or the RNC group (T=10, n=10, p<0.035). However, this difference was significant for the MCT group (T=2, n=10, p<0.0045)[all one-tailed].

The measurement of clinically significant change

Figures 15.8, 15.9 and 15.10, shown overleaf, describe the distribution of Dysfunctional Attitude Scale scores on admission and at follow-up. Each group comprised ten subjects.

Figure 15.8 : Distribution of DAS Scores - SE Group

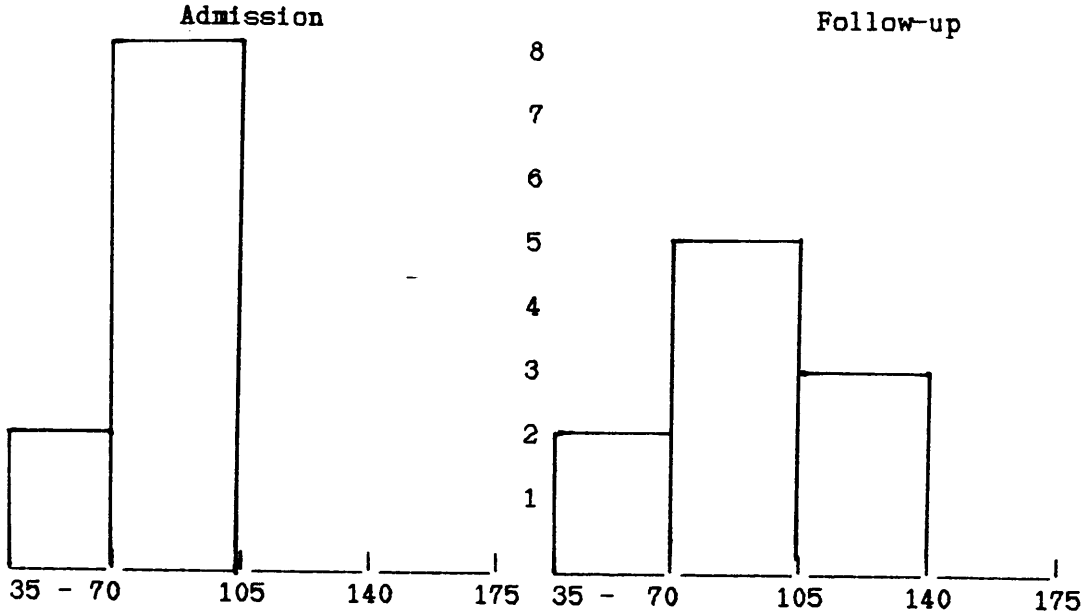


Figure 15.9 : Distribution of DAS Scores - RMC Group

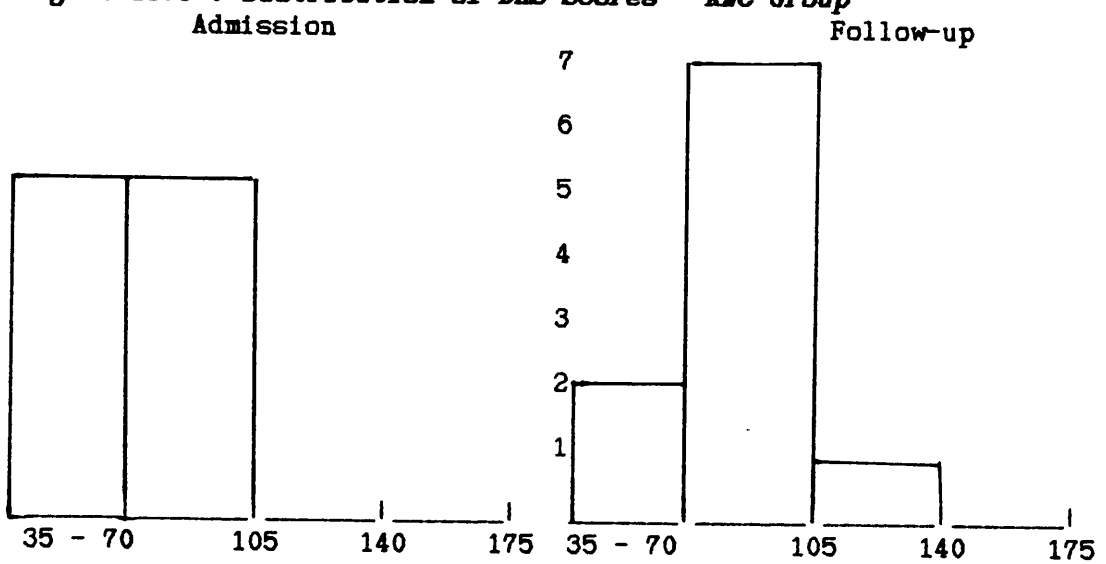
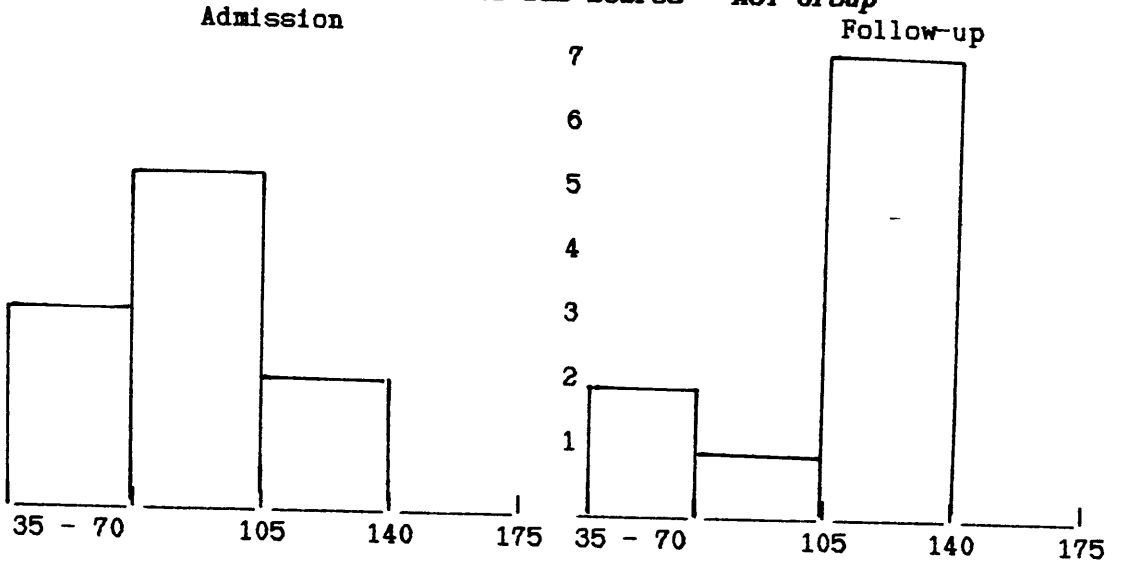


Figure 15.10 : Distribution of DAS Scores - MCT Group



On admission, all the SE subjects scored below 105. Three subjects scored beyond this level at follow up. The RNC subjects' scores were equally divided on admission between the 35-70 and 70-105 ranges. At follow-up, three scores had changed, with two additional scores within the 70-105 range and one within the range 105-140. The MCT group had the most widely distributed scores of the three groups on admission, with three subjects within the range 35-70, five in the 70-105 range and two in the range 105-140, At follow-up five scores had moved from the lower ranges to within the range 105-140.

Follow-up scores were analysed using the SC Index of Christensen and Mendoza (1986). Index scores are presented in Table 15.6. Only one subject from the SE Group and two subjects each from RNC and MCT showed a change at Christensen and Mendoza's five per cent level. Using the data from the normative sample, a cut-off score of 98.2 was determined

(one standard deviation below the mean). Three subjects from SE, two from RNC and seven from MCT scored above this cut-off point at follow-up. However four of the MCT subjects' admission scores were above this cut-off point on admission. Consequently only three MCT subjects *changed*, from below to above this cut-off point, at follow-up.

Table 15.6 : DAS - SC Index Scores (After Christensen & Mendoza (1986)

	SE	RNC	MCT
1.	2.30 *▲	1.01	3.02*
2.	-0.78	1.01	0.22
3.	1.58 ▲	-0.57	1.08
4.	0.22	3.66*▲	1.87 ▲
5.	1.36 ▲	2.58*▲	0.86
6.	-0.43	0.65	0.86
7.	0.00	0.00	1.65 ▲
8.	-1.01	0.00	3.73*▲
9.	0.29	1.94	-0.22
10.	1.08	-0.22	0.22

* = $p<0.05$
▲ = scores which moved from below, to above the cut-off (98.2).

A comparison of these SC index scores, using the Kruskal Wallis One Way Analysis of Variance, showed no significant difference between the groups (H=1.99, df=2, *ns*). A further comparison of the SC index scores was made, between those who were 'significantly changed' on this index and those who were not. Using the Chi Square test, no significant difference was found between those who were, and those who were not, significantly changed within the three groups (x^2= .47, *df* = 2, ns). The considerations, regarding the appropriateness of this test noted earlier in the ATQ30 and BDI analyses, are relevant here also, where three of the six cells (50%) had expected frequencies of less than 5.

4 Dependent variable 4 : locus of control

The subjects' view of their ability to influence or control their depressive symptoms was described as their 'locus of control'. This variable was measured using the Depression Locus of Control Scale (DLCS), which was described in Part Two. The scale was administered on admission to the study, at discharge and at the six-month follow-up. Two hypotheses were stated in relation to this dependent variable;

Null Hypothesis 7. Measures of locus of control on the DLCS will not differ significantly between the three groups RNC, SE and MCT at discharge.

Research Hypothesis 7. The MCT group will yield significantly lower, more internalised scores, on the DLCS, compared with the other two groups, at discharge.

Null Hypothesis 8. Measures of locus of control on the DLCS will not differ significantly between the three groups, RNC, SE and MCT at follow-up.

Research Hypothesis 8. The MCT group will yield lower, more internalised, scores on the DLCS, compared with the other two groups at follow-up.

Overview of the DLCS data. Mean scores, score range and standard deviations for the three groups, on admission, at discharge and at follow-up are shown in Table 15.7.

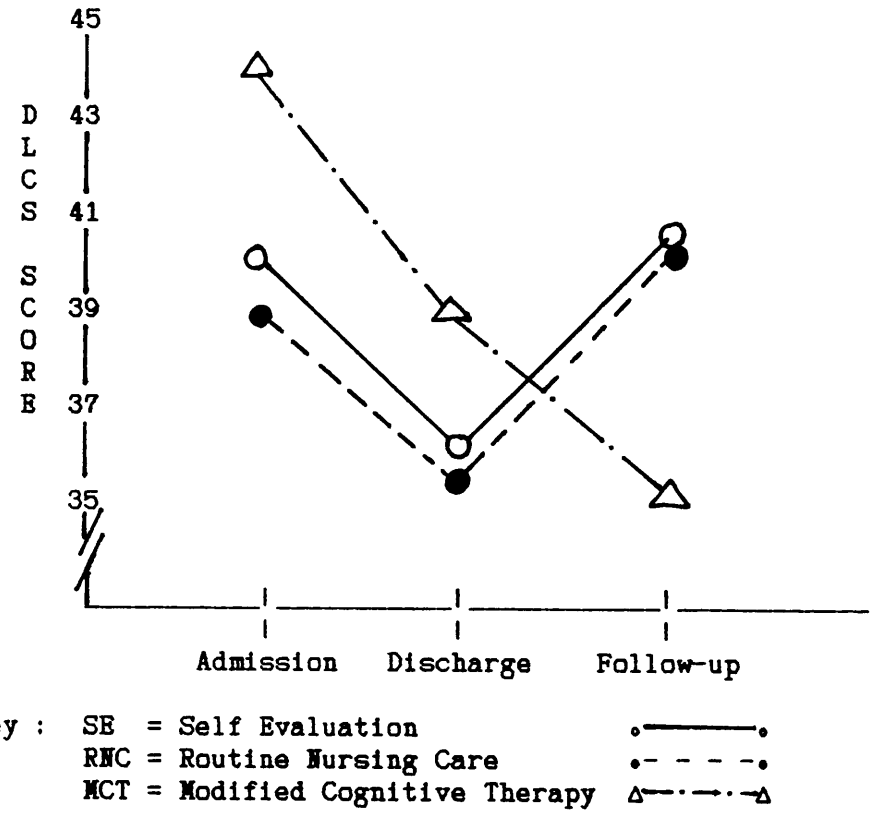
Table 15.7 : Means, Range and Standard Deviations for the DLCS

Group	Admission	Discharge	Follow-Up
SE $\bar{X}$ (SD)	40.1 (6.0)	36.1 (5.4)	40.9 (6.5)
Range	33 - 51	29 - 45	32 - 54
RNC $\bar{X}$ (SD)	38.7 (3.7)	35.4 (4.9)	40.7 (4.2)
Range	32 - 44	29 - 44	34 - 48
MCT $\bar{X}$ (SD)	44.4 (8.7)	39.2 (8.5)	34.9 (8.5)
Range	32 - 58	25 - 58	21 - 52

Key : SE : Self Evaluation
RNC : Routine Nursing Care
MCT : Modified Cognitive Therapy

On admission, the MCT group mean was higher (more externalised) than the means of the other two groups and also showed the widest score range. At discharge, all three group means showed a decrease. At follow-up, mean SE scores returned to the admission level but the RNC subjects scores were higher, on average, than on admission. Only the MCT subjects showed a decrease in mean scores over their admission and discharge scores. No large-sample norms using this instrument were available for comparison purposes. However, admission scores for the three groups were within the 'normal limits' of the the manic-depressive sample reported in Part Two ('depressed only' subjects $\bar{X}$=44.42, SD=5.47; 'mania & depression' subjects $\bar{X}$=40.24, SD=5.22). The trend of the group means and score range is shown in Figure 15.11.

Figure 15.11 : Mean ratings for the DLCS [1]



[1] The author acknowledges that these data points are not continuous. The mean scores are represented here in graph form merely as an aid towards clarification of the trend of the group means.

Between groups analysis

Null hypotheses 7 and 8 predicted that there would be no difference between the Depression Locus of Control (DLCS) scores of the three groups, on discharge (7) and at follow-up (8). Research hypotheses 7 and 8 predicted that the MCT group would yield lower (more internalised) scores than the other two groups, on discharge (7) and at follow-up (8). Given that three independent groups were under study, a test for *k* independent samples was required, to test for between-group differences. The data produced by the DLCS involved ordinal

measurements, therefore the nonparametric, Kruskal-Wallis One-Way Analysis of Variance by Ranks, was selected. The significance level was set at .05.

On admission, no significant difference existed between the three groups (H = 2.32, *df* =2, ns). The same one-way analysis of variance compared the subjects' scores at discharge and follow-up.

Hypothesis 7. At discharge, no significant difference existed between the three groups (H = 1.65, *df* =2, *ns*).

Hypothesis 8. At follow-up, no significant difference existed between the three groups (H = 5.19, *df* =2, *ns*).

Multiple comparisons. The research hypotheses 7 and 8 had predicted that the MCT group would show lower (more internalised) scores than either of the other two groups. Paired comparisons are usually only undertaken when significant between-groups differences are evident. As noted above, the Kruskal-Wallis test found no significant difference between the three groups at discharge, or at follow-up. However, to clarify further possible differences between the three groups, paired comparisons were undertaken using the Mann Whitney U test, which was appropriate for a two condition, unrelated design, where different subjects are used for each condition, and the data involve ordinal measurements. Since the research hypotheses (7 and 8) predicted that the MCT group would have lower scores than the other two groups on discharge and at follow-up, comparisons between MCT and other groups at

these points involved one-tailed tests, with the significance level set at .025. All other comparisons involved two-tailed tests, with the significance level set at .05.

The paired comparisons showed no significant difference between MCT and the other two groups on admission: SE and MCT (U = 35, *ns*: two-tailed) RNC and MCT (U = 32, *ns*: two-tailed). At discharge, no significant difference existed between MCT and the other two groups SE and MCT (U = 38.5, *ns*: one-tailed) RNC and MCT (U = 33.5, *ns*: one-tailed). At follow- up the difference between MCT and SE failed to reach significance level (U = 25.5, $p<0.04$: one-tailed), but a significant difference did exist between MCT and RNC (U = 23, $p<0.025$: one-tailed).

Within groups analysis: A. To clarify whether changes had occurred in the DLCS scores *within groups*, across the stages of the study, two further analyses were undertaken. In the first, the admission, discharge and follow-up DLCS scores from each group were compared. Since these three sets of scores were drawn from the same group, representing a related design, and the data represented ordinal measurments, Freidman's Two-Way Analysis of Variance by Ranks was selected as the appropriate nonparametric test for a related design. Significance level was set at .05.

No significant change was found for the SE ($\chi_r^2=16.15$, df=9, *ns*) or the RNC group ($\chi_r^2=15.75$, df=9, *ns*). However, the change in the MCT group scores was significant at beyond the one per cent level ($\chi_r^2=24.51$, df=9, $p<.004$).

Within-group analysis : B. To test whether the follow-up DLCS scores were lower (more internalised) than admission scores, a second within-groups analysis was undertaken. Since this analysis involved a two-sample, related design, using ordinal measurements, the Wilcoxon Signed-Ranks Test was selected as the appropriate nonparametric test. Since the direction of the change was predicted, a one-tailed test was used, with the significance level set at .025.

No significant difference between admission and follow-up DLCS scores was found for the SE and RNC groups: SE (T=27, n=10, *ns*) and RNC (T=26.5, n=10, *ns*). However, a significant change in the MCT subjects' scores was demonstrated (T=0, n=10, $p<0.0025$).

The measurement of clinically significant change

The distribution of DLCS scores for the three groups is presented in Figures 15.12, 15.13, and 15.14. This distribution shows that, on admission, nine out of the ten SE subjects and all the RNC subjects scored within the 30 - 50 range. Six of the MCT subjects scored within this range, the remaining subjects registering even higher scores in the range between 50 and 60. At follow-up, the distribution of SE scores remained unchanged. The RNC subjects showed only one change, this being in a negative direction. At the final evaluation, however, the distribution of MCT scores showed that the number of subjects scoring *below* 40 had doubled.

Figure 15.12 : Distribution of DLCS Scores - SE Group

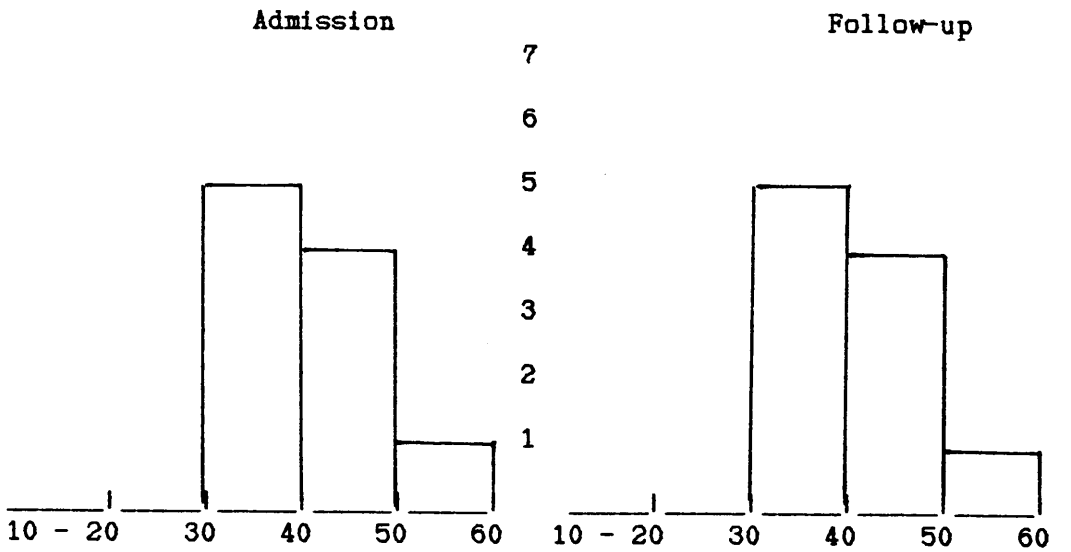


Figure 15.13 : Distribution of DLCS Scores - RMC Group

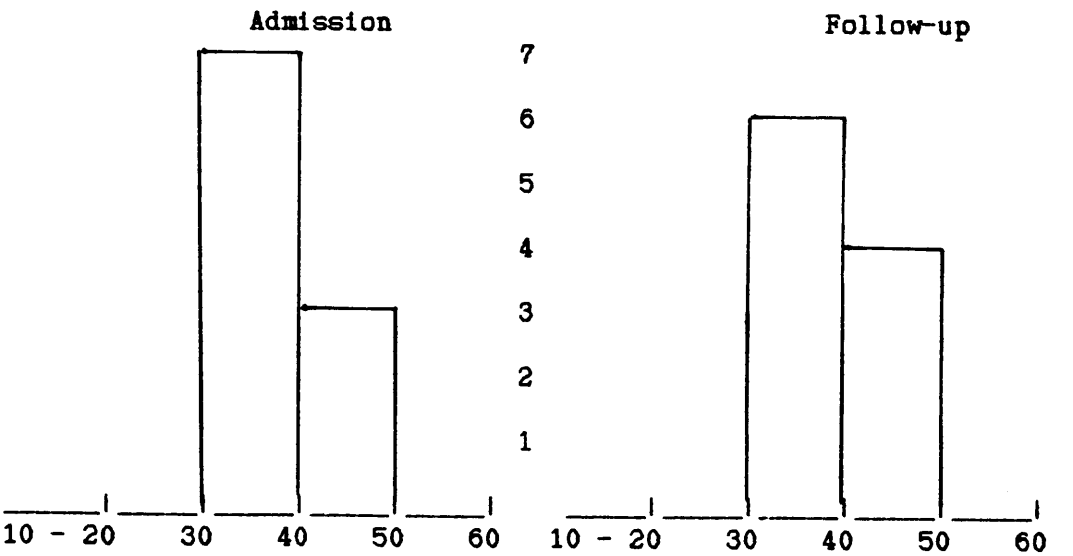
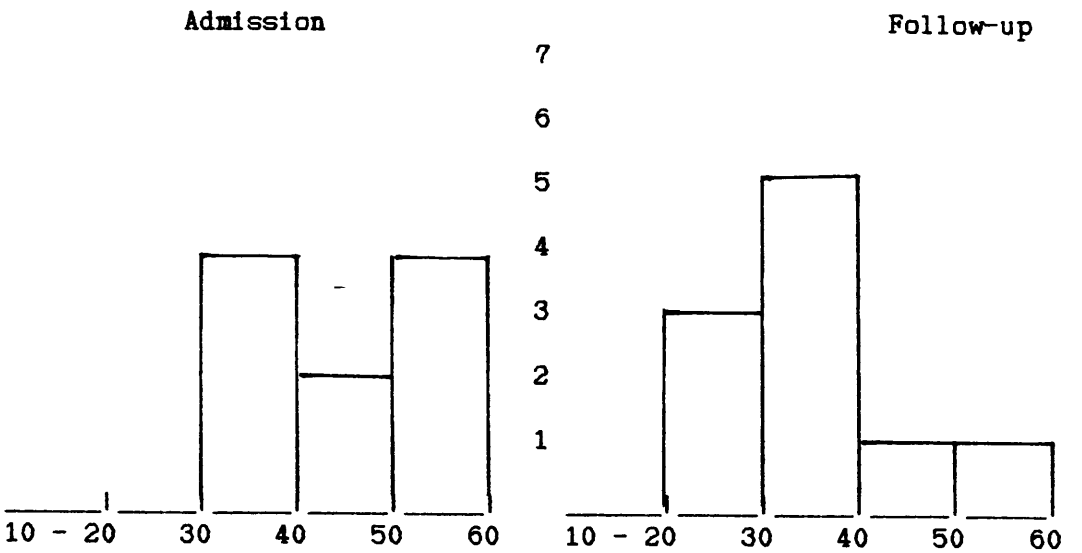


Figure 15.14 : Distribution of DLCS Scores - MCT Group



The DLCS follow-up scores were analysed using the SC index. Index scores are presented in Table 15.8.

Table 15.8 : DLCS - SC Index Scores

	SE	RNC	MCT
1.	3.03	1.10	-3.03*
2.	0.00	0.28	-3.86*
3.	-0.55	0.00	-3.58*
4.	-1.37	0.00	-1.65
5.	0.83	4.41	-2.20*
6.	0.83	-0.28	-1.65
7.	0.00	0.00	-6.06*
8.	-0.83	0.00	-0.83
9.	0.00	0.00	-1.38
10.	0.28	0.00	-1.92

* = $p<0.05$

Using the SC Index, only three SE subjects and one RNC subject showed a more internalised score on follow-up. None of these changes reached the level of significant change defined by Christensen and Mendoza. All of

the MCT subjects, however, showed a reduction in their DLCS scores, five passing Christensen and Mendoza's five per cent significance level. Comparison of these SC index scores, using Kruskal Wallis One-Way Analysis of Variance, showed a significant difference between the groups (H=19.53, *df*=2, p<0.0001).

C: Analysis of the Measure of the Dependent Variable, Satisfaction with Care and Treatment.

Satisfaction with care and treatment was measured by the Patient Satisfaction Scale (PSS). The hypothesis stated in relation to this variable was as follows:

Null Hypothesis 9. Measures of satisfaction with care and treatment on the PSS will not differ significantly between the three groups at follow-up.

Research Hypothesis 9. The MCT group will show higher scores on the PSS than RNC or SE at follow-up.

Only 14 subjects (47%) returned the Patient Satisfaction Scales (PSS) following the final follow-up interview (six MCT, four SE and four RNC subjects). This meant that a meaningful comparison between the three groups was not possible. In this section, the data provided by these respondents will be discussed, amplified by some of the comments made by the subjects in response to some of the statements in the scale. The 35 items on the scale represented six inter-related facets of the 'care' offered to the patient on the ward. These involved the subject's

ratings of her level of 'satisfaction' with: her orientation to the ward, the nursing team, her care, her medical treatment, the involvement of her family and 'general factors'. The total and sub-scores from the 14 respondents on the scale are shown in Table 15.9.

Table 15.9 Patient Satisfaction Scale: Total and sub-scores (n=14)

Items	Orient'n (1-5)	Nurses (6-13)	Care (14-16)	Medical (17-24)	Family (25-30)	Gen. (31-35)	Total
Maximum	20	32	12	32	24	20	140
$\bar{X}$	11.2	23.5	8.4	18.3	13.1	15.8	90.4
Range	4-18	16-29	4-12	8-30	4-20	13-18	60-112

No subjects scored between 0 - 35 ('very dissatisfied'); one subject scored between 36 - 70 ('dissatisfied'); nine subjects scored between 71 - 105 ('satisfied'); and four subjects scored between 106 - 140 ('very satisfied').

Scale sub-sections

All respondents made at least one comment against their score on one of the items on the scale. Some of these comments are presented below, under the sub-section headings, in an attempt to illustrate the views of the respondents to their care.

Orientation. The first five statements related to aspects of the patient's introduction and orientation to the ward. Most of the respondents were reasonably satisfied with their introduction to the ward (mean = 11.2; maximum possible = 20). Some of the subjects had difficulty remembering the details of their admission and orientation.

Only three subjects scored less than ten in this section. Selected comments are presented verbatim below. An attempt was made to select comments from each of the three groups, in relation to the item, in an attempt to represent the view of group members. Only items which were commented upon by more than two subjects, were selected for illustration.

1. How much information were you given about your admission to the ward?

> My state of mind caused me to shut out staff. Didn't want to be bothered (RNC subject).
>
> I was upset and I just couldn't think straight (SE subject)
>
> Very confused (MCT).

5. Was your treatment explained to you?

> I was put on a course of pills 'two of this and two of that' and then two of the next thing 'sleeping pills' (RNC subject).
>
> The cognitive therapy help offered(sic). Treatment in ward consisted of preparing me for this although at the time a bit confusing (MCT subject).

Nurses. Statements 6 to 13 dealt witht the patient's view of the nursing team. In general the respondents appeared satisfied with the nursing team (mean = 23.5; maximum possible = 32). Only one subject scored below 20 in this section. The following selected comments illustrate their views.

6. How willing were the nurses to speak to you?

> The nurses were really great, from sister, charge nurse, staff nurses, nurses and enrolled nurses. Myself, I think I could have been a better patient (RNC subject).
>
> I sometimes found it difficult to talk, even if they began the conversation (MCT subject).

7. **Did the nurses explain things to you as they went along.**

I was told when a certain doctor would be seeing me later in the day to have a talk with me. I was told by the nurse not to worry about that, so that was reassuring (SE subject).

11. **How much understanding did the nurses have of your illness?**

They knew every step of the way (MCT subject)

Students in first year, I think don't understand as much as qualified nurses (SE subject).

13. **How did the nurses deal with your problems?**

Very helpful (MCT subject).
If I did have a problem the nurses would tell me not to worry and sit down beside me and explain things to me (RNC subject).

General care. Three statements dealt with general aspects of care on the ward. Respondents scores ranged from low to high 'satisfaction' (mean = 8.4; maximum possible = 12).

16. **What did you think of the nursing care you received overall?**

Two words sum that up 'very good' (RNC subject).
Excellent. Follow up visit made me realise this (MCT subject).

Medical treatment. Eight statements dealt with aspects of the medical treatment: interviews with the doctor, drugs etc. The responses here were variable. Some subjects were very satisfied, others critical of the medical service (mean = 18.3; maximum possible = 32). Although these items were intended to assess only the medical 'treatment', some of the responses appeared to evaluate the nursing intervention: the two comments from MCT subjects in question 24, appear to reflect their experience of the MCT intervention.

20. **What did you think of the doctor's answers to your questions?**

The answers from the doctor were more like questions back to me. I would get confused and the doctor would say 'that's fine. That's enough for today'. Poor soul I got him confused (SE subject).

24. **Did you get the kind of treatment and help you wanted?**

It was different from what I had known before. Felt I was learning something about myself (MCT subject).

Yes, to some extent, as I did not knw what was wrong with me. Still don't (RNC subject).

Now I realise that this was probably the best way as I had a bigger hand in my own cure (MCT subject).

Family. Five statements dealt with the involvement of the patient's family in her admission, care and dicharge (mean = 13.1; maximum possible =24). Responses ranged from very low (4) to high 'satisfaction'(20). Much of the 'dissatisfaction' appeared to involve communications about discharge, where five subjects commented that they 'passed on' all the necessary information to their relatives.

26. **How much opportunity did your family have to discuss your illness with staff?**

Not too sure that they wanted to (be involved) anyway (MCT subject).

We wanted an opportunity to discuss it together and <u>not</u> my husband alone with the doctor. This was denied us(SE subject).

General. The last five statements dealt with general evaluations of care on the ward: freedom, spare time, individual attention etc. Most of the respondents expressed relative 'satisfaction' with their care and treatment overall (mean = 15.8; maximum possible = 20).

34. **Do you feel that you were treated as an individual on the ward?**

I felt that I should conform (RNC subject).

'Not at all', there were patients worse off than me, and who I thought needed a little bit of help and comfort more than others(RNC subject).

D: Analysis of the Measure of the Dependent Variable, Length of Hospital Stay and Drug Treatment

Length of stay on the ward and medical treatment were determined on an individual basis. To assess the possible influence of hospitalisation and individually tailored drug regimes, the three groups were compared on these two, uncontrolled variables.

Length of stay. The length of stay over all subjects ranged from one month to seven months. The length of stay for each group (mean and standard deviation) is summarised in Table 15.10. A between-groups comparison , using Kruskal Wallis One Way Analysis of Variance by Ranks, showed no significant difference between the three groups on this variable (H=2.48. df=2, *ns*).

Table 15.10: Length of Stay: weeks - Mean, range and standard deviation.

	SE	RNC	MCT
$\bar{X}$(SD)	8.9(4.8)	11.1(4.5)	12.6(6.7)
Range	4 - 17	4 - 27	5 - 21

Drug treatment. The individually-tailored drug regimes were assessed in terms of the number of weeks each subject received the minimum therapeutic dose of any *antidepressant* or *anxiolytic* drug. Scores

ranged overall between 4 (where the subject received only one drug) and 61 (where the subject received several drugs during her stay). Drug scores are summarised for the three groups in Table 15.11.

Table 15.11. Drug treatment scores: mean, range and standard deviation

	SE	RNC	MCT
$\bar{X}$ (SD)	11.5(8.04)	15.7(16.1)	14.3(6.7)
Range	4 - 26	5 - 61	5 - 28

A comparison of these drug treatment scores, using Kruskal Wallis One Way Analysis of Variance by Ranks, showed no significant difference between the three groups (H=1.75, df=2, *ns*).

CHAPTER 16

DISCUSSION OF PART THREE

Overall Evaluation of The Subjects

The main (experimental) study aimed to compare the effects of three discrete forms of nursing intervention on the presentation of women diagnosed as suffering from manic depressive psychosis. The study was evaluated by comparison of the three groups on admission, at discharge from the study, and at a six-month follow-up. The three groups, Routine Nursing Care (RNC), Self Evaluation (SE) and Modified Cognitive Therapy (MCT), were compared in terms of *between-group* and within-group differences at each stage of the study. No significant differences existed between the three groups of subjects on admission, in terms of age or number of previous admissions to hospital for depressive illness.

A: Outcome Evaluation at Follow-up. The study tested nine discrete hypotheses which are discussed below, in relation to each of the dependent variables. A general evaluation of the subjects was provided by the identification of their status at the final follow-up evaluation, six months after discharge. Three subjects from the Routine Nursing Care (RNC) group and two subjects from the Self Evaluation (SE) group had been readmitted, at some stage during the six month period following discharge. Although this evaluation of 'patient status' does not describe the subjects further, it suggests that the Modified Cognitive Therapy (MCT) subjects were not showing overt symptoms of

affective disorder, sufficient to require their re-admission, at the six month follow-up.

B: The Analysis of the Measures of Dependent Variables

Characteristic of Affective Disorder

Dependent variable 1 : Depression

This variable was measured by the Beck Depression Inventory (BDI), on admission, at discharge and at follow-up.

Two hypotheses were stated in relation to this dependent variable:

Null Hypothesis 1. Measures of depression on the BDI will not differ signficantly between the groups RNC, SE and MCT at discharge.
Research Hypothesis 1. The MCT group will yield lower BDI scores than RNC or SE at discharge.

Null Hypothesis 2. Measures of depression on the BDI will not differ significantly between groups RNC, SE and MCT, at follow-up.
Research Hypothesis 2. The MCT group will yield lower BDI scores than RNC or SE at follow-up.

Assessment of the subjects showed that the three groups' BDI scores were similar on admission and at discharge. Although the mean scores of all three groups were reduced at follow-up, significant differences existed between the groups. Although only RNC and MCT groups showed significant changes across the three phases of the study, significant changes between admission and follow-up scores were present for all

three groups. Paired comparisons at follow-up showed that the MCT groups was significantly more improved on this measure than the other two groups. Given that no significant differences existed between the three groups at discharge, null hypothesis 1 was not rejected. Significant diferences between the three groups existed at follow-up, and these were in the direction predicted by the research hypothesis. Consequently null hypothesis 2 was rejected.

The analysis also considered the extent to which the subjects' BDI scores showed *clinically significant changes* across time. On admission, only four subjects scored within the borderline range for clinical depression (17 - 20), whereas more than half of the subjects scoring within the 'severe depression' and 'extreme depression' ranges. Although, at follow-up, almost two-thirds of the total sample scored within the range of 'mild mood disturbance' or the non-depressed range, the representation of MCT subjects was greater here than either of the other two groups. Indeed, only one of the MCT subjects scored within the range of clinical depression ('borderline') with seven subjects from this group scoring within the 'non-depressed - normal' range. By comparison, six RNC and five SE subjects scored *above* the cut-off point for the definition of clinical depression, five of these scoring within the 'severe' and 'extreme' ranges.

Differences between the groups were evident also using Christensen and Mendoza's 'significant change' formula. Only three SE and five RNC subjects showed *clinically significant* change, whereas all ten MCT

subjects showed significant gains, in terms of lowered Beck Depression Inventory scores, on this index. These analyses suggest, not only that the MCT group showed lower follow-up depression scores, but that most of this group returned to within 'normal limits' on this measure. The research hyppotheses had predicted that the MCT group would show lower scores on the BDI scale over the two other groups at discharge (1) and follow-up (2). As noted above, significant differences were present only at follow-up. Given that all subjects were discharged when 'affectively well' on the basis of a psychiatric interview, this may explain why no significant difference existed between the groups on the BDI at discharge. The follow-up evaluations were, however, influenced by the readmission of five subjects. In the case of the BDI analysis, the readmission ratings were accepted as 'follow-up' scores. This procedure can be criticised on the grounds that instead of evaluating these five subjects six months after discharge from treatment, they were assessed at the beginning of another hospitalisation. The readmitted subjects could have been omitted from the follow-up analysis. Since the study aimed to 're-assess' the subjects at six months, to judge whether improvement or regression had occurred, the use of the readmission ratings may represent the most acceptable, albeit imperfect, evaluation of 'follow-up' for these subjects.

The analysis of the Beck Depression Inventory (BDI) data provides clear indications of differences in the responses of the three subject groups, on this measure, across time. The Routine Nursing Care (RNC) group showed significant changes across the three phases of the study, and were significantly improved at follow-up, compared with their

admission scores. The Self Evaluation (SE) group was significantly improved at follow-up, but did not show significant changes across the three phases of the study. The Modified Cognitive Therapy (MCT) group showed significant improvement at follow-up, over admission scores; over the three phases of the study; and were significantly more improved at follow-up than either of the other two experimental groups. Although significant differences did not exist between the Significant Change (SC) index scores, every subject in the MCT group showed clinically significant change, compared with only five RNC subjects and three from the SE group. Taken together, these between-group, within group and normative comparisons provide strong support for the superiority of the Modified Cognitive Therapy (MCT) intervention over Routine Nursing Care (RNC) and the Self Evaluation (SE) intervention, in the reduction of *depression*, as expressed by the reduction of scores on the Beck Depression Inventory (BDI).

Dependent variable 2 : negative automatic thoughts

This variable was measured by the Automatic Thoughts Questionnaire (ATQ30), on admission, at discharge and at follow-up. Two hypotheses were stated in relation to this dependent variable.

Null Hypothesis 3. Measures of negative automatic thoughts on the ATQ30 will not differ significantly between the three groups RNC, SE and MCT, at discharge.

Research Hypothesis 3. The MCT group will yield lower scores on the ATQ30 than RNC or SE at discharge.

Null Hypothesis 4. Measures of negative automatic thoughts on the ATQ30 will not differ significantly between the three groups RNC, SE and MCT, at follow-up.

Research Hypothesis 4. The MCT group will yield lower scores on the ATQ30 than RNC or SE at follow-up.

No differences existed between the groups' ATQ30 ratings on admission. More than three quarters of the subjects' scores were more than one standard deviation above the mean of the two samples used for normative comparison, showing the dysfunctional nature of the sample as a whole. Although all three groups showed reductions at discharge and follow-up, the follow-up scores which fell within 'normal limits' represented just more than one third of the total sample; more than half of these came from the MCT group.

No significant difference between the groups was evident at discharge or follow-up. Significant changes were shown, however, for each group over the full length of the study and for admission/follow-up comparison. Although paired comparison in the absence of significant between group differences is questionable, this analysis showed significantly greater reductions in ATQ30 scores for MCT at follow-up over the RNC group. However the difference between MCT and SE was not significant.

Six subjects each from the RNC and SE groups showed a significant clinical change on Christensen and Mendoza's SC index, with nine MCT subjects passing this criterion. Statistical comparison of the index

scores, however, showed no significant differences between the groups. In the absence of significant between-group differences at either discharge or follow-up, the null hypotheses 3 and 4 were not rejected. However, the paired comparisons suggest that the MCT group scores were lower than those of the other two groups and, perhaps more importantly, the normative comparison described a more obvious downward trend, towards the range of 'normal limits' for this measure.

The relationship between the subjects' Beck Depression Inventory (BDI) and ATQ30 scores is also worthy of comment. Seven MCT subjects fell within normal limits on the BDI; six MCT subjects scored within the normal range on the ATQ30. Three SE and four RNC subjects scored within normal limits on the ATQ30, two and three subjects respectively, falling within normal limits on the BDI. Eaves and Rush (1984) reported that endogenous depressed *(sic)* subjects' ATQ scores were reduced to a normal level with recovery, whereas an *unremitted* group continued to report a higher frequency of negative thoughts. In the main (experimental) study reported here, the number of subjects within each group who returned to within normal limits on the BDI, was similar to the number of subjects who returned to within normal limits on the ATQ30. However, since a correlation between ATQ30 and BDI scores was not undertaken, the exact nature of this relationship is not clear. It could be argued, however, that as subjects became less 'depressed' (reduced scores on the BDI), they engaged in less negative thinking (shown by reduced ATQ30 scores). Teasdale and Fogarty (1979) have presented evidence for this view, suggesting that depressed mood tends to increase accessibility of negative thinking.

An alternative view would be that subjects may become less depressed as they reduce the frequency of their negative thinking. A third interpretation would be that the two sets of measures are co-related, but have no causal relationship with each other. Alladin's (1985) empirical test of Beck's cognitive theory presented the confusing conclusions that i) negative thinking was best regarded as a *consequence* of depression, varying as a function of sex and severity of depression; and ii) that non-depressed *anxious* controls showed a similar 'depressive' thinking style, thereby challenging the Beck's claim concerning the specificity of negative thinking to depression. The inconclusiveness of similar findings had encouraged Rush and Giles to suggest that it was unclear whether cognitive distortions were aetiological, descriptive, or epiphenomenal (cited by Alladin, 1985). The design of the experiment reported here prohibits any further clarification of these hypotheses.

The three nursing interventions, Routine Nursing Care (RNC), Self Evaluation (SE) and Modified Cognitive Therapy (MCT), all focussed upon these 'cognitive distortions', albeit in different ways. Although process data were not collected, from the descriptions of the nursing care provided in Part One, it can be assumed that most of the RNC and SE group interactions dealt with the patient's thoughts and feelings, and their relationship to her life in general. The nurses in the RNC were encouraged to approach the patient's 'thoughts' in the manner described in the literature and the sub-studies reported in Part One. The nurse allowed the patient to 'set the agenda' for the interaction, providing support, encouragement and expressions of understanding, in

an attempt to facilitate further discussion of depressive themes. The SE group used a similar approach, adding structure to the discussion by use of the 'identification and rating' card, which in turn became the focus for a more structured 'problem-solving' discussion. Although the content of the 'self evaluation' cards was not studied closely, the nurses reported that subjects typically described negative self-evaluations, such as "I'm no good to my husband any more", or made negative predictions: "I won't be able to speak to him". Although the interactions did not focus exclusively on negative thoughts to the exclusion of negative affect, the emphasis upon negative thoughts appeared to be the primary focus. The MCT group subject, however, received a discrete alternative in the form of interactions which offered consistent explanations of her negative thinking as a 'style', common in depression. The 'patient's manual' (see Appendix 19) reinforced the 'normal' status of such negative thinking in depression, and offered practical strategies for identifying thoughts and challenging them, or in critical situations, avoiding some of their negative impact by distraction, immersion in activity or self-talk procedures.

Although differences between the three groups on the ATQ30 can be interpreted as consequences of differing reductions in negative affect, these changes in the level of negative thinking might also be attributed, at least in part, to the different styles of 'thought manipulation' present within the different types of nursing interactions. The traditional style of interaction offered to the RNC group emphasised 'ventilation' of *feeling*. It can be assumed that this

'feeling talk' embraced thoughts as well as emotions, in the sense described by Ellis (1962):

> ...human thinking and emotion are *not* two different processes...they significantly overlap and are in some respects the same thing (p.38)

Although the RNC interactions had no specific 'ideological' base, in the author's view the RNC group nurse's orientation reflected Ellis' view of the 'wholistic' nature of human experience: when a person senses something, he also tends to do something in response to that sensation, having at the same time feelings and thoughts about the sensation and his own behaviour. However, the RNC nurses largely concluded their 'exploration' of the relationship between thoughts, feelings and the patient's behaviour, once the patient had expressed herself. Any practical exploration, by the patient, of ways of confronting, resolving or circumnavigating the negative experiences described in her 'thoughts' was undertaken in a largely unstructured, unsystematic manner. It might be assumed that these interactions brought emotional relief, where negative thoughts or feelings were 'released'. It is possible that subjects might also have become more aware of their thoughts and perhaps have adjusted these, as a function of the interaction. However, since the specification of such a goal was not on the RNC nurse's agenda, the possibility that RNC group subjects might have 'benefitted' from such an interaction is no more than conjecture.

The SE group encouraged the patient to set the agenda in a similar fashion, but provided more structure to the examination of thoughts, feelings and ways of resolving problems. Although no specific problem-

solving format was employed, subjects were encouraged to explore alternative ways of looking at and dealing with situations, in the manner described by D'Zurilla and Goldfried (1971), subsequently weighing up the pros and cons of different strategies. The MCT group approach was described in some detail in Chapter 14, and is perhaps best represented by the structure and content of the 'patient's manual' (Appendix 19). The key differences between MCT and the two other interventions lay in the MCT group nurses' use of *a clearly defined rationale* and *specific techniques* of behavioural and cognitive manipulation. The RNC and SE group nurses did not attempt to explain the phenomenom of negative thinking from any specific theoretical standpoint. The MCT group nurses, however, repeatedly emphasised the contiguous relationship between thoughts and feelings, this conceptual model being illustrated further in the manual (see Appendix 19).

Six RNC subjects and six SE subjects showed a significant positive clinical change in their ATQ30 scores, three of the former and only two of the latter falling within normal limits. By contrast, nine MCT subjects showed a significant clinical change, six of these falling within normal limits. One might have expected the SE group to have made more gains than the RNC subjects, given their discrete emphasis upon problem-solving. It might be posited, however, that the emphasis on problem-solving, especially within a relatively unstructured context, generated anxiety for the subjects, who were required to take responsibility for their depressive thoughts and their possible resolution. Alladin's (1985) study suggested that elevated anxiety, at discharge, was more likely than depression to maintain negative

thinking style. At the level of maximum speculation, it can be hypothesised that the problem-solving approach, for some subjects, may have maintained levels of negative thinking, through the stimulation of a form of performance anxiety. By contrast, the supportive atmosphere of the RNC group may have allowed as much, if not more, problem-solving to take place, in a situation where no obvious pressure was placed upon the patient to take such an initiative for herself.

The relative success of the MCT group on the ATQ30 could be attributed to their greater improvement in levels of depression at follow-up. Alternatively, it could be suggested that the rationale and strategies afforded this group allowed them the opportunity to 'learn' more about their thinking style and its effects on their mood levels. Some behavioural studies (such as Foa & Kozak, 1986; Lang, 1979) have suggested that the amount of change which occurs during therapy is directly proportional to the degree to which feeling, thoughts, attitudes, behaviour and physiological responses are *accessed*, or available to the patient's conscious awareness during treatment. Persons and Burns (1986) called this the "accessing hypothesis". The early interactions with the MCT subjects emphasised helping the patient to develop awareness of feelings and thoughts, helping her distinguish between somatic (or physiological) feelings and 'psychic' emotions, involving thinking and imagery. By projecting examples of depressive experiences in the manual, the author hoped to assist the nurses to project a form of 'predictive empathy' (Alpher and Turkat, 1986) in an attempt to reinforce the credibility of their alternative conceptualisation of the patient's problems. The MCT group was

presented with more clearly defined strategies for manipulating negative thinking than the other two groups. These were supported by a 'logical' rationale made credible to the patient by illustration of depressive thoughts and feelings which were consonant with the patient's own experience. At a speculative level, these elements of the MCT approach can be viewed as factors which played an important role in the reduction of negative thinking within this group.

Although all three groups showed significant reductions in their ATQ30 scores at follow-up, the majority of those who made the most significant clinical changes, in terms of ATQ30 scores returning within normal limits, came from the MCT group. Comparison of pairs of groups at follow-up showed that the MCT group made significantly greater gains over the RNC group only, in terms of reduction in ATQ30 scores. The difference between MCT and SE failed to reach significance. Therefore, the null hypotheses 3 and 4 were not rejected.

Dependent variable 3 : dysfunctional beliefs

This variable was measured by the shortened Dysfunctional Attitude Scale (DAS) on admission, at discharge and at follow-up. Two hypotheses were stated in relation to this dependent variable:

Null Hypothesis 5. Measures of dysfunctional beliefs on the DAS will not differ significantly between the three groups RNC, SE and MCT at discharge.

Research Hypothesis 5. The MCT group will yield higher DAS scores than RNC or SE at discharge.

Null Hypothesis 6. Measures of dysfunctional beliefs on the DAS will not differ significantly between the three groups RNC, SE and MCT at follow-up.

Research Hypothesis 6. The MCT group will yield higher DAS scores than RNC or SE at follow-up.

Between group comparison revealed no significant differences between the three groups on admission, at discharge or at follow-up. Significant changes across the full duration of the study were present only for the SE and MCT group, with significant admission versus follow-up differences present only for the MCT group. Paired comparisons at discharge and follow-up showed no significant differences between the three groups. On the basis of these analyses Null Hypotheses 5 and 6 were not rejected.

Comparison of admission and follow-up scores showed that three subjects each from SE and MCT and two from the RNC group moved from below to above the normative cut-off score, indicating positive gains for these subjects. However, analysis of these scores, using Christensen and Mendoza's significant change index, showed that only one SE subject and two each from the RNC and MCT groups had made a clinically significant change.

None of the experimental nursing interventions manipulated directly the subjects' dysfunctional beliefs which were assessed on the DAS. As noted above in the section on negative thinking, it can be assumed that all three groups dealt with the kind of negative thoughts which

projected at least some of the views held by the patient on herself and her world. However, in the absence of process data it is not clear to what extent any of the three groups manipulated the dysfunctional 'needs' for approval, love, achievement, perfectionism, entitlement, omnipotence and autonomy, which were measured by Burn's version of the DAS. The nurses who were trained to work with the MCT group were offered no specific training in accessing underlying dysfunctional belief systems, and no specific attention was paid to this area in the patient's manual (see Appendix 19). It is commonly accepted that the depressed person is not aware of these 'silent assumptions' (Burns, 1980), by which she construes herself and her world and which form the basis for the definition of her personal worth. Consequently, it is accepted that the identification and confrontation of these belief and value systems is a sophisticated process, outwith the bounds even of supportive psychotherapy. It can be assumed, therefore, that direct manipulation of such 'emotional vulnerabilities' was not on the agenda of any of the experimental groups.

It is perhaps unremarkable that the majority of subjects showed no major change in DAS scores occurred, given that none of the groups attempted, directly, to deal with dysfunctional beliefs. Why some subjects showed significant changes, however, is unclear. Although an abbreviated version of Weissman and Beck's scale was used, these results lend qualified support to the findings of earlier studies (such as Eaves and Rush, 1984) which reported *non-significant* changes in the dysfunctional attitudes of patients with *major depressive disorder*. Although neither study attempted to manipulate negative attitudes, both

Dobson and Shaw (1983) and Eaves and Rush (1984) found that, although their subjects showed a reduction in DAS scores with clinical remission, their dysfunctional attitude scores remained higher than a normative comparison group. Eaves and Rush concluded that negative attitudes behaved as trait, rather than state, variables. In this study, most subjects remained unchanged, or made non-significant gains at follow-up. This may support the hypothesis that small gains are dependent upon clinical remission. However, given that a small proportion of subjects made significant changes in DAS scores, may question whether DAS scores represent trait, or state, variables, which are amenable to manipulation.

The view that negative attitudes, as measured by the DAS, are the *symptoms* or effects of depression, rather than attitudinal precipitants, was proposed by Schreiber (1978). Empirical suppport for this hypothesis was provided by Silverman, Silverman and Eardley's (1984) study, where drugs and supportive psychotherapy produced a significant diminution of DAS scores in a sample of 35 depressed patients. These authors argued that supportive psychotherapy could not account for such a "rapid and dramatic improvement in attitudes about life" (p.29). In a concurrent survey of several groups of psychiatric patients, Silverman *et al. (1984)* reported that *asymptomatic* depressives displayed "if anything, less maladaptive thinking" than other psychiatric patients. In their sample, 10 bipolar depressives were "as healthy as control subjects" on the DAS (p.30). Silverman *et al.*'s conclusion that the maladaptive attitudes of depressives are corrected automatically in the course of recovery is, however, questionable on

the grounds that their sample used only private patients, among whom chronic depressives "refractory to drug and electroshock therapy" did not exist.

Parker, Bradshaw and Blignault's (1984) study of 43 patients with 'neurotic or reactive depression' showed that those who improved most on the Zung depression scale showed the greatest gains in DAS scores. Their conclusions echoed Hamilton and Abramson's (1983) findings that, rather than a possible cause, dysfunctional attitudes were a function of depression. Both Eaves and Rush (1984) and Giles and Rush (1982) found that the DAS failed to discriminate between 'endogenous' and 'non-endogenous' depressed subjects. Consequently, these conflicting conclusions cannot be attributed unequivocally to differences in the subject sample.

The study reported here fails to show a consistent scoring pattern of changes on this measure. Only the MCT group showed significant changes across the whole study and between admission and follow-up. However, between-group comparison showed no significant differences at discharge or at follow-up. Consequently, null hypotheses 5 and 6 were not rejected.

Dependent variable 4: locus of control

This dependent variable was measured by the Depression Locus of Control Scale (DLCS) on admission, at discharge and at follow-up. Two hypotheses werestated in relation to this dependent variable:

Null Hypothesis 7. Measures of locus of control on the DLCS will not differ significantly between the three groups RNC, SE and MCT at discharge.

Research Hypothesis 7. The MCT group will yield significantly lower, more internalised scores, on the DLCS compared with RNC and SE groups.

Null Hypothesis 8. Measures of locus of control on the DLCS will not differ signficantly between the three groups RNC, SE and MCT at follow-up.

Research Hypothesis 8. The MCT group will lower, more internalised scores on the DLCS, compared with RNC and SE at follow-up.

No significant differences between the groups was found on admission, at discharge or at follow-up. Within-group analysis showed no significant change for the SE and RNC groups across the three stages of the study, but demonstrated a significant change in the MCT subjects scores ($p<0.004$). A similar picture emerged from the admission and follow-up comparions. No significant differences were present for the SE and RNC scores but a significant change was detected in the predicted direction for the MCT subjects ($p<0.0025$). On the basis of these analyses, null hypotheses 7 and 8 were not rejected.

Although the use of paired comparisons, in the absence of between group differences, is questionable this analysis was undertaken to clarify the comparison of the three groups. No significant difference between pairs of groups showing the most extreme score profiles was shown on admission or at discharge. Follow-up comparison between pairs of

groups, however, showed that the MCT subjects scores were significantly lower (more internalised) than the RNC group, but did not differ significantly from those of the SE group.

In the absence of a large scale normative comparison group, it was difficult to draw meaningful conclusions about the nature of scores which had shown positive changes during the study. Analysis of the data using Christensen and Mendoza's significant change index showed no significant change for any subject's scores from the SE and RNC groups, only three SE and one RNC subject showing a reduction over their admission score at follow-up. By comparison, all ten MCT subjects scores were reduced at follow-up, five of these passing the Christensen and Mendoza criterion of significant clinical change ($p<0.0001$). Although null hypotheses 7 and 8 were not rejected the consideration of all analyses, including the measurement of clinically significant change, suggests that the MCT group showed more consistent change across the study, showed greater levels of clinically significant change and showed more significant 'improved' scores at follow-up, over the other two groups.

The subject's view of herself as a depressed person was not manipulated directly in any of the interventions. The assumptions concerning the manipulation of dysfunctional attitudes, which were discussed above, apply here also. The DLCS purported to measure the extent to which the patient expresses *internal*, rather than *external*, locus of control. This construct can be interpreted as a variant of self-esteem, expressing some of the attitudes the subjects holds about herself. Coleman (1975) suggested that self-esteem demonstrates a causal, rather

than correlational, relationship with depression and elevation of mood. In Wilson and Krane's (1980) laboratory study, subjects were required to read positive, negative or neutral self-statements. Subjects who read negative self-statements reported a subsequent significant lowering of self-esteem, with significantly higher depression, social withdrawal and depression ratings, than subjects who read positive or neutral self-statements. Wilson and Krane's study not only suggests that self-esteem can be manipulated in the laboratory, but supports Coleman's earlier findings that cognitively induced lowering of self-esteem predictably influences the reporting of levels of depression.

It can be assumed that all three interventions studied here aimed to encourage the patient to view herself in a more positive, constructive manner. Much of the nursing literature pertaining to depression, reviewed in Part One, identifies the manipulation of self-esteem as an important area. Emphasising the worth of the patient and maximising levels of self-esteem, was one of Cormack's (1983) *therapeutic use of self* categories, from his observational study of psychiatric nursing practice. As noted in the literature review in Part One, what is not clear is *how nurses achieve this goal*. Although reassuring the patient of her worth may achieve a short-term 'inflation' of self-esteem, it remains to be demonstrated that such support is anything other than palliative, and might be seen as debilitating in the long term. In the context of their study of manic depressive patients, Cohen *et al.* (1954) observed that, as children, future manic depressives were constantly observed by critical parents, who expected model behaviour from them in order to bring honour upon the family. Beck (1976) presented a similar

view of the influence of critical parental attitudes shaping negative views of the patient's self in adult life. Arieti's hypothesis concerning the 'dominant other' in interpersonal relations is apposite to any discussion of depression. In Bemporad's (1980) view the depressed person's childhood experience of the parent involves:

> ...reactive learning...whereby the child is made to become a desired ideal which does not necessarily resemble the parent, in order to win love or escape punishment (p.165)

Bemporad argues that depressives appear to be products of excessive 'reactive learning'. As a result they develop reactive identities:

> ...he (the depressive) functions best in a role that reflects the dictates of the dominant other rather than any independent standards. These individuals require the presence of an external agency in order to derive satisfaction, and they are unable to gain pleasure from independent achievement (p.165).

Both the interpersonal and cognitive theorists appear to implicate *past* relationships in the aetiology of depression but emphasise the importance of changing *present* relationships in order to reduce depression. These 'relationships' are especially exemplified in the patient's *thoughts* about, and behaviour towards, herself and those who make up her world. All three experimental nursing interventions aimed to 'boost' the patient's self-esteem, encouraging her to tackle nd resolve her 'problems of living'. If the DLCS is a valid measure of the patient's locus of control, then the RNC and SE interventions appear to have made no impression on this particular aspect of the subject's self image. Alternatively, the MCT group showed highly significant changes in their DLCS scores, suggesting that the approach adopted by the MCT group nurses may have helped the subject to distance herself from her stereotyped view of herself as a chronically depressed (and

ineffectual) person. The data suggest that these subjects became more internalised, indicating that their view of their own capacity to control external sources of reinforcement, increased as a function of their exposure to the training in self-management, intrinsic to the MCT approach.

C : Analysis of the Dependent Variable, Satisfaction with Care and Treatment

This dependent variable was measured by the Patient Satisfaction Scale (PSS) at the follow-up, six months after discharge. The hypothesis stated in relation to this dependent variable was as follows:

Null Hypothesis 9. The measure of satisfaction with care and treatment on the PSS will not differ significantly between the three groups at follow-up.

Research Hypothesis 9. The MCT group will show higher levels of satisfaction on the PSS than the RMC or SE groups at follow-up.

All subjects were invited to complete the PSS independently at home, returning the scale by post to the author. Five subjects were readmitted and were, therefore, ineligible for completion of this retrospective evaluation. Only 14 of the remaining 25 subjects returned completed questionnaires to the author. This rendered meaningful comparison between the three groups impossible.

Although a between-group comparison was inappropriate, the available data suggested that the majority of the subjects who responded were 'satisfied' or 'very satisfied' with their care and treatment. The comments abstracted from the returns suggested that the patient's recollections of admission were vague and some appeared to recollect being quite passive. Satisfaction with the nursing team *per se* was high: most subjects who made comments, praised the nursing staff in general. Few of the subjects made specific reference to the content of care, apart from general descriptions of reassurance, receipt of information concerning meetings with medical staff, and time nurses spent 'explaining things'. The evaluation of medical care and treatment was variable and was confused further by comments which appeared to reflect the subjects' appreciation of aspects of the experimental nursing intervention. Some dissatisfaction was expressed concerning staff contact with family, relating in particular to comments about information regarding discharge arrangements. With this exception the critical comments added by the respondents were focussed upon medical, rather than nursing, attitudes.

One of the subjects responded 'not at all' to the question concerning treatment as an individual, adding that there were other patients worse off than her. This comment may reflect the self-deprecating attitude common among many depressed patients, but may also suggest that not all depressed patients are self-absorbed to the extent that they fail to notice the needs of their peers. The focus of the scale, upon the patient as an *individual*, rather than 'one of many', may have failed to

acknowledge broader considerations about the context of care, which the patient was in a good position to assess.

Almost one third of the questions dealt with 'communication' between the staff and the patient. A specific score for this was not computed. Given the emphasis upon the 'working relationship' between nurse and patient, this may have been an oversight.

The decision to review the measures of 'satisfaction' and accompanying comments as a whole, rather than undertake the between-group comparison planned, was influenced by two issues concerning the low return rate. First, the distribution of completed scales (seven MCT, four SE and three RNC) did not represent the three groups equally. It may also be that 'satisfaction' and 'recovery' are related and that those subjects who were motivated to return the questionnaire, were sufficiently recovered to wish to communicate this. It was notable, however, that although medical staff members were singled out for direct criticism in some comments, no critical comments of the nursing team were made. It could be hypothesised that the 11 eligible subjects who failed to return the scale, were dissatisfied with their care and treatment, but were not motivated to communicate their views. The apparent readiness of research subjects to respond positively to such 'consumer satisfaction' studies has drawn comment from other researchers:

> Pressures towards conformity and tendencies toward an agreeing response set could be expected to be enhanced in the situation where patients are asked to evaluate the agency which is currently treating them or which may treat them again in the future (Albers, 1977).

In view of the 'chronic' status of the patient sample, many of whom might have expected to be readmitted to the research ward at some stage, it is perhaps unsurprising that so many were open in their 'praise' of the nursing team.

The view that *only* satisfied patients respond to such surveys has also been noted by Kalman *et al.* (1982) who studied an affective disorder population, under what appeared to be similar conditions. The Kalman *et al.* study population completed their 18-item questionnaire *before* discharge, and had an opportunity to list the "least pleasing" and "most helpful" aspects of their hospitalisation. The questionnaire also asked subjects directly how they felt about tests conducted during their stay. The PSS, which was developed before publication of the Kalman study, aimed to test possible differences between subject's views of their care and treatment. In retrospect, it appears to be too broad to generate such an evaluation. Although scores on specific sub-scales could be drawn from the total score, as noted above the responses to some of items suggested that subjects were confusing 'medical' treatment and 'nursing' care. The wording of the questions was largely to blame for this confusion. Since the subjects were invited only to add 'comments' below each question, it is unsurprising that many of these comments were general, rather than specific, in nature. Few of the comments revealed the patients views on actual nurse-patient interactions. On reflection, the PSS was limited by the absence of both 'open' and 'highly specific' questions.

The decision to invite the patient to complete and return the scale independently may have contributed to the low return rate. Completion of the scale in the nurse's presence ,at the follow-up evaluation was rejected on the grounds that the nurse's presence might be intrusive. However, the length of the scale (twice the length of the Kalman *et al.* scale), the presence of open 'comments' sections with *each* question, and the requirement to post the scale (although already stamped-addressed) may have been too demanding for some subjects. It may also be that some subjects, once 'affectively well', wish to forget the experience of depression, but may not wish to offend the nurse researcher by refusing outright to complete such follow-up measures.

In view of the return rate of the questionnaire, the experimental hypothesis was not amenable to examination. On the basis of the available data, however, it could be hypothesised that had such a comparison been possible, the conclusions might not have been meaningful. Those subjects who responded, appeared to make be making general evaluations of their care and treatment. Such a comparison may have failed to isolate anything other than chance differences between the three experimental groups. Given that each subject received only one 'form' of care, her evaluation was essentially 'situation specific'. However, subjects who received a different form of care, such as the MCT or SE groups, might have made a comparison between this, and previous, experiences of care. Apart from very general observations (e.g. "It was different from what I had known before"..."Felt I was learning something about myself"..."I had a

bigger hand in my own cure": all MCT subjects) no obvious comments were made comparing the most recent and previous experiences of care.

Some respondents expressed great satisfaction with the nurses. Although no clear differences between nursing and ward medical staff were identified, some comments suggest that the patients saw nurses and doctors quite differently. Of the nursing staff they commented:

> The nurses were really great...; They knew every step of the way;...the nurses would sit down beside me and tell me not to worry.

Comments which specified medical staff reflected a different kind of appreciation

> The answers from the doctor were more like questions back to me...; We wanted an opportunity to discuss it (my illness) together... This was denied us.

These comments, although perhaps not representative of the whole sample, appear to question Macilwaine's (1981) view that

> patients were as likely to see nurses as pill-givers and waitresses...as to value them for providing support and reassurance" (p.1159).

Instead, the subjects appear to reflect the 'need for affiliation' described by Shanley (1984), where friendship-relationships serve an anxiety reduction function. It could be hypothesised that if nurses undertook a more *formal* psychotherapeutic role, they might be viewed as less accessible and less supportive; becoming more like the 'non-directive' psychiatrist who 'reflects' questions back to the patient. However, from the evaluation of the comments of the MCT group, who were exposed to a nursing approach which was quite different from 'routine practice', this shift in appreciation was not apparent.

D: Analysis of the Measures of the Dependent Variables, Length of Hospital Stay and Drug Treatment.

Length of stay and nurse contact. All subjects admitted to the study were discharged when the medical and nursing staff team considered that they were 'affectively well' and ready to return home. All patients were interviewed by two psychiatrists, whose individual views, combined with general reports from the nursing team, were considered at the weekly case conference. In some cases, this assessment was influenced by domestic factors, such as family support. The conditions surrounding the discharge of every patient were not studied in detail. It was assumed, however, that the prime criterion for the discharge of the patient was her perceived affective state. This arrangement meant that the length of stay on the ward varied. In the case of the experimental subjects, this ranged from one to seven months. Statistical comparison of the three groups revealed no significant difference between the groups on this variable. Although it cannot be stated that length of stay did not play an important part in determining the final outcome evaluation of any individual patient, no significant differences existed between the groups overall on this variable.

The length of stay had a direct influence on the amount of time the patient spent in staff contact. Given that the time spent in contact with subjects was monitored each week through the 'time log', each subject spent relatively similar amounts of time in staff contact. The major difference between subjects, therefore, is represented by total

time in hospital which, as noted above, was not significantly different between the three groups.

Drug treatment. In an attempt to control for the effect of specific drugs, or drug combinations, a procedure was developed prior to the commencement of the study to control the range of antidepressant and anxiolytic medication offered to the experimental subjects. A list of appropriate drugs was defined by the consultant psychiatrist in discussion with the author, in an attempt to reduce between-subject differences in drug treatment. The resulting drug regimes were individually tailored, albeit within the confines of the recommended drug list. The author and the consultant psychiatrist also agreed that, where necessary, a patient could be withdrawn from the study and referred for electro-convulsive therapy. Four subjects were withdrawn in this manner, two from the MCT group and one each from the other two groups. Four subjects also exercised their right to withdraw from the study, two each from the SE and RNC groups.

Statistical comparison of the three groups failed to reveal any significant differences between the three groups on the drug treatment variable. This raises the possibility that drug therapy, combined with nursing intervention, may have effected positive changes in the patients' presentation but whether or not such positive changes can be attributed to the effect of drugs *alone. It is, however, conceivable that subjects who made the significant positive changes on the dependent measures were in receipt of different combinations of medication and experienced longer periods of stay than subjects who*

showed less significant gains. Although possible, there is no evidence to suggest that this was the case.

It should also be recognised that longer periods of stay, or higher scores on the drug treatment rating, do not necessarily represent more treatment. Indeed, some patients respond to minimum therapeutic doses of single antidepressant drugs and are discharged within a few weeks of admission. Additional drug prescriptions, or longer periods of stay, are commonly associated with *failure to respond* to the initial intervention (Naylor, 1987). Regular, brief contact with the subject throughout the week was a feature of the exerimental design of this study, found in few other experimental studies of psychotherapeutic intervention. Most controlled studies (e.g. Blackburn *et al.*,1981; McLean & Hakstian, 1979; Murphy *et al.*, 1984; Rush *et al.*, 1977) have involved weekly or twice-weekly 'sessions', usually with out-patients. Although comparisons between nurses employing cognitive methods and clinical psychologists and psychiatrists, who may have received highly specialised training in cognitive therapy, are not appropriate, *contrasts* between styles of interaction (such as 'sessions' *versus* daily contact) may be important.

Consideration of the experimental design

The overall significance of the findings from the study depends greatly upon the intrinsic value of the experimental design. Some reservations can be made, in retrospect, concerning the method and materials employed.

The subjects. The small size of the total sample suggests that caution requires to be exercised in drawing conclusions from the findings. The size of the groups was influenced in part by the stringent criteria for the selection of subjects, which rejected first-time admissions and patients who did not meet the diagnostic criterion. The consent procedure meant that only those subjects capable of giving consent were included and any wishing to withdraw were free to do so. These two features can, however, be viewed as methodological *assets.*

Although the subject sample all met stringent *research* diagnostic criteria, this assessed the subjects only on their immediate presentation. Although the subjects can be classed as 'manic depressives', as noted in the introduction (Chapter 1) much dispute exists over the validity of different clinical and research diagnoses. The supervising psychiatrist, who has considerable academic standing in the field of affective disorder research, had no reservations about describing the subjects as 'manic depressives'. He acknowledged, along with the author, however, the inexact nature of this traditional diagnosis.

Kupfer and Rush (1983) argued that the diagnostic composition of the sample, in depression research, should i) identify the number of bipolar I and bipolar II subjects and ii) should report the number of 'psychotic' (hallucinating and/or delusional) subjects. The bipolar classification is drawn from the DSMIII (American Psychiatric Association, 1980). Although Kupfer and Rush's recommendations were published after the experimental design of the reported study had been

completed, failure to distinguish more clearly between subjects with a past history of mania as well as depression, must be seen as a major methodological deficit. The study sample also contained subjects who, at some stage, reported auditory hallucinations and expressed feelings of guilt which were considered to be of delusional proportions. These subjects were not distinguished from the rest of the sample who did not show these 'psychotic' features. Whilst acknowledging the rationale for the identification of subjects with *psychotic* depression, doubts can be expressed concerning the validity of using the presence of hallucinations and/or delusions as the *primary* distinguishing feature of psychotic depression, as Kupfer and Rush suggested.

Arieti (1980) observed that although the term *psychosis can indicate actual or potential severity of a disorder*, it also connotes that an unrealistic way of appreciating the self and the world is accepted, as a normal way of living. In practical terms:

> ...the patient who is depressed to a psychotic degree has undergone predominantly a severe emotional transformation, but he believes that his way of feeling is appropriate to the circumstances in which he lives. Thus he does not fight his disorder, as the psychoneurotic does, but lives within it (p.59).

In Arieti's terms, all the subjects involved in the study would be classed as psychotic. It is acknowledged that this approach to classifying patients, for clinical or research purposes, is unconventional. From a nursing research viewpoint, however, whether patients accept passively, or reject actively, their feelings of depression seems to have important implications for the provision of of appropriate care.

The description of the subjects failed to report any socio-economic variables or to provide a description of previous treatment, prior to admission, or within past admissions. Given the sociological evidence regarding the role of social variables in the precipitation of depression, especially in women, this represents a major methodological flaw. Although no differences existed between the groups in terms of previous hospital admissions, this was no more than a crude index of 'chronicity'. Assessment of the subjects' receipt of, and response to, previous drug therapy, ECT, and psychological interventions, might have clarified whether subjects were 'resistant' to appropriate treatment (Checkley, 1986), inadequately treated (Kupfer and Freedman, 1986) or relapsing depressives.

Given that only female subjects were involved, their ovarian status could have been noted and monitored, especially given the age range of subjects. It should not have been assumed that menstrual factors were irrelevant, even in the case of discrete disorders such as manic depressive psychosis, which are assumed to be beyond the influence of such biological processes.

Length of follow-up. The decision to conclude follow-up at six months was taken jointly by the author and the consultant psychiatrist, who acted as a specialist advisor. At the time the study was being planned, this period was considered to be the acceptable minimum. In the intervening period, Elkin *et al.* (1985) recommended that depression studies should report follow-up data at 6, 12 and 18 months. These authors were critical of studies which reported only up to one year

follow-up (e.g. Kovacs *et al.*, 1981). Although the follow-up data presented provides a basis for some conclusions about the effects of the independent variables, the six month follow-up must be seen as a less-than-acceptable time scale to monitor outcome, even in 'chronic' subjects, who might be expected to relapse rapidly.

Evaluation. The subjects were evaluated solely by means of self-report ratings. Although a rationale for their use was presented in the method section, other researchers would challenge the exclusive reliance upon self-report ratings. Kupfer and Rush (1983) suggested that although a self-report scale may be useful it is not essential, for depression research. These authors recommend instead "at least one clinican-rated method with proven reliability and validity" (p.1328). It could be argued that since *nursing* is concerned primarily with the patient's *experience* of illness (Wilson-Barnett, 1985), self-report represents the most vital index of response to nursing care. The absence, however, of any independent evaluation (preferably by a blind rater) of the patient's presentation is recognised, however, as a methodological deficit.

It should also be acknowledged that with the exception of the BDI the other three measures of the characteristics of depression (ATQ30, DAS and DLCS) were biased towards measures of cognitive processes, and as such were more likely to be influenced by the Modified Cognitive Therapy approach. Although the BDI measured a range of features associated with depression, it measured them only from the patient's viewpoint and may represent a further bias in favour of manipulation

by a cognitive intervention. Two of the dependent measures, the BDI and the ATQ30, had been validated and proven to be reliable in previous studies. The version of the DAS used in the study had been used, to the author's knowledge, in only one other reported major study. This version was selected as a simpler scale to administer, especially to severely depressed subjects. The DLCS was designed specifically for this study, as described in Part Two. It is acknowledged that not only was this measure field-tested to only a limited degree, but the absence of normative data for this measure made interpretation of the findings of the main study difficult.

The process of change. *The absence of 'process' data was noted in the discussion of dependent variables above. Documentary data from the following three areas would have assisted greatly in the interpretation of the findings: descriptions of actual nurse-patient interactions* within the three groups; the *behaviour* of subjects during interactions, especially details of the thoughts and feelings accessed, and the specific problems of living focussed upon; the actual *responses* of the nurses to different presentations of the patient, and how often different responses were employed with different subjects. It is acknowledged that such an examination of process variables was not part of the original design. However, as noted in the discussion of the dependent variables, major assumptions are required in order to interpret the practical significance of the results. Even in the case of the MCT group, where the experimental format permitted the nurse very little freedom, process data would have clarified greatly the

exact nature of the subject's problems and the nature of the 'help' she received from the nurse.

Comparison of the three nursing interventions

The results from the experimental study suggest that differences exist betwen the three nursing interventions, in terms of their effect upon some aspects of the patients presentation. Despite the failure to reject most of the null hypotheses, there were clear indications that the MCT group made greater gains on the BDI, the ATQ30 and the DLCS. Furthermore, the MCT group made more 'clinically significant' changes than the other experimental groups on all four dependent measures. Four possible differences between the three interventions are examined below:

1. The MCT group received the most credible intervention.
2. The MCT group received the most acceptable intervention.
3. The MCT nursing team differed from their their colleagues in the other two groups.
4. The MCT group were offered more direct help for their immediate problems of living.

1. ***The MCT group received the most credible*** **intervention.** The MCT intervention was the most complex of the three interventions. The nurses use of the manual, the visual aids, flip chart and the patient's use of the manual and record sheets, distinguished this intervention from the others. It could be argued that these features lent greater credibility to this intervention. Alternatively, it could be argued

that this approach might have represented a 'culture shock' to subjects used to more traditional forms of nurse-patient interaction. Although no data were collected on the patients view of the MCT approach one respondent commented on the PSS questionnaire that "the cognitive therapy help offered (was)...at the time a bit confusing." Another MCT subject commented that "it was different from what I had known before." The author has acknowledged already that discrete attempts were made to present the MCT model as meaningful and relevant to the experiences of the patient. However, it is assumed that all interpretations of psychiatric disorder or psychological distress are projected in a similar fashion, albeit not in the style displayed by the MCT approach.

The credibility of any therapy was discussed by Kazdin and Wilcoxon (1976) who suggested that if the patient found the therapy plausible, this might modify efficacy expctations and enhance treatment outcome. A study of the treatment of depressed patients by McLean and Hakstian (1979) controlled for possible 'plausibility' factors by providing each intervention with a rationale and similar homework assignment formats. In the present study the *physical* differences between the three inteventions (manual, record sheets, visual aids, flip chart etc) may have added status to the rationale offered by the nurse. The presentation of the cognitive therapy strategies and explanations in the manual may also have reinforced the 'authority' of the material, thereby enhancing at least the compliance of the patient. It could also be argued, however, that patients who expected to discuss their feelings, receive solutions or advice, or more likely just be given

medication or ECT, might have been upset by the encouragement and to take responsibility for solving her own problems.

2. The MCT group viewed their care as a more acceptable, or appropriate, nursing intervention. Two subjects each from the SE and RNC groups asked to withdraw from the study during their period in the ward. No specific reason was given, other than an unwillingness to continue. Since no MCT subjects withdrew, it could be hypothesised that they found their care more acceptable in some way. It is more likely that some 'aversive' element, rather than dissatisfaction, encouraged the withdrawals to drop out of the study. Brockway, Plummer and Lowe (1976) showed that even increased nurse communication about the patient's illness can have an interaction effect, increasing anxiety in those who denied their illness and reducing anxiety in patients who accepted that they were ill. It could be hypothesised that some subjects found the exposure to examination of their 'problems of living' too stressful. In this context, it could be argued that the MCT subjects should have found their care equally distressing, given the emphasis upon encouraging the patient to *challenge* negative thinking, conduct behavioural *experiments* and to *monitor* activity and thinking.

3. *The MCT nurses differed from the nurses in the other two groups.* Due mainly to the availability of staff, one 'team' of nurses worked with the SE and RNC groups, another 'team' working solely with the MCT subjects. It could be argued, therefore, that the MCT nurses saw their subject group as more special and, as a result, showed more committment to the MCT intervention. Since they were manipulating a 'new'

intervention, the MCT group nurses may have been more enthusiastic about their approach, or might simply have been more stimulated by the demands of the approach, compared to their colleagues in the other groups. It is conceivable that such enthusiasm and stimulation might have produced a 'placebo effect' of its own (Shapiro and Morris, 1978).

The nurses involved with the RNC patients were encouraged to support, and reassure the patient as appropriate, and to use suggestion, rather than direction in terms of problem solving. The same team was encouraged to assist the SE group subjects to construct meaningful solutions of their own to apply to the problems in their lives. The MCT team worked to the most rigorous remit, using the manual as their guide. However, since the interactions of nurse and patient were not studied directly, the extent to which these three teams used these distinct approaches is unclear. It is possible that some nurses might have directed the patient; others might have been more facilitative. Also, the extent to which the patients responded to either directive or facilitative conditions is unknown and needs to be studied.

Of all these consideration, the status of the MCT nurses as a 'special' team, working with only one group of patients, may be most important. This singular responsibility may have had a significant effect on the nurses' view of themselves as therapeutic agencies. However, such am interpretation is speculative.

4. ***The MCT group received training in everyday problem-solving.*** All three groups were encouraged to identify and attempt to resolve their

'problems of living'. For the RNC group, this consisted largely of *talking* about feelings and thoughts, and *discussing* possible solutions, which the patient might, or might not, implement. The SE group used a more structured approach, committing the problems to paper, and weighing up possible options in a simplified form of 'problem-solving' (D'Zurilla & Goldfried, 1971). This approach involved the use of simplified 'self-control' strategies: working out, in practical terms, how to deal with their fears, cope with worrying thoughts or plan the organisation of trips home. The MCT group clearly were involved in a more 'concrete' programme of self-awareness, critical self-examination and experimentation. The reading of the patient's manual as recommended 'homework', the use of the activity records, thought-catching record sheets, and negative-thought challenging records, provided these subjects with materials which may have helped them develop a more objective awareness, by *distancing* themselves from their thoughts, feelings and everyday patterns of behaviour.

The MCT group were offered what can only be described as *training*: in 'catching' thoughts; challenging negative thinking; planning more satisfying or necessary everyday activity; overcoming obstacles presented by lethargy, fear etc; distracting attention away from painful thoughts when appropriate; or using distraction to reduce painful emotions when appropriate. All these training 'exercises' were undertaken in the same intimate, confidential atmosphere enjoyed by the subjects in the other two groups. The emphasis upon formal 'lifeskills' training for the severely depressed patient appears to be the most distinguishing characteristic of the MCT group. The RNC group received

'soft', intuitive, responses from the nurse, which were determined wholly by the patient's presentation, on any particular day. Although the SE group received a slightly more structured form of care, the content of each session was decided on an *ad hoc* basis and was a response to the projected 'needs' of the subject. The MCT group not only was the most structured of the three interventions, but the format of the interactions was determined largely in advance. Although the nurses were required to be sensitive to the patient's presentation, the manual guided the timetable of 'training', and represnted a relatively inflexible care system. Specific comments were not solicited from the subjects regarding their perceptions of these interventions at the time of their delivery. The Patient Satisfaction Scale (PSS) data revealed little more than random, general, observations of how they felt about this innovative system of care on recovery. The extent to which this highly directive, if not confrontative, approach would meet with the approval of all severely depressed patients is not clear.

Summary.

This study suggests that three different forms of nursing intervention produced different patterns of responses on selected dependent variables of women diagnosed as suffering from manic depressive psychosis. The Modified Cognitive Therapy (MCT) intervention was associated with greater improvement in depression scores at a six month follow-up over the other two experimental groups, both of which presented with relapsing subjects. Differences between the three groups on measures of negative thinking and dysfunctional attitudes were much less clear. Although the MCT group made greater gains on these two

dependent measures, statistical comparison between the three groups provided only qualified support for the superiority of the MCT intervention, in the case of the ATQ30 analysis. Of greater interest was the finding that only a small proportion of subjects showed any reduction in levels of dysfunctional attitudes, echoing recent findings from other studies of major depressive disorder. The study featured a novel examination of locus of control measures in depression, employing a scale designed specifically to assess the severely depressed subject's view of herself as a depressed person. The MCT group demonstrated greater degrees of change on this measure. The possible clinical significance of these findings was enhanced by the finding that two uncontrolled variables, length of hospital stay and drug treatment, did not differ significantly between the three groups. The study had intended also to compare levels of satisfaction between the three groups, on the care received during their stay within the experimental project. Poor return rates excluded such an analysis, but the available data provided some opportunity for an evaluation of the views of the experimental subjects.

PART FOUR
CHAPTER 17

CONCLUSIONS AND RECOMMENDATIONS

Review of the Research

The main objective of the studies described within the thesis was to examine the effect of different kinds of nursing care upon patients described as suffering from manic depressive psychosis. The study comprised three interrelated sections, reported in Parts One, Two and Three of the thesis.

Nursing the patient with affective disorder

In Part One, the role of the psychiatric nurse in caring for people suffering from affective disorder in general, and manic depressive psychosis in particular, was examined. Three major perspectives were employed in this examination. A review of the nursing literature was presented in two sections. Selections from text books were used to illustrate 'recommended practice': this represented *prescriptions* for care. A brief review was conducted also of reports in the nursing literature of orientations, practices, procedures and outcome of nursing care in Britain over the past decade: these represented *descriptions* of care. The British literature was considered finally and compared and contrasted with the influential American psychiatric nursing texts and other published reports.

The second perspective focussed upon an examination of the training syllabus for Registered Mental Nurses in Scotland. The sample

curriculum, as it pertained to care of patients with affective disorder, was reviewed, followed by an evaluation of examination questions which were specific to the care and treatment of depression. These questions were judged by a panel of 17 senior clinical nurses, in an effort to clarify whether or not the questions reflected any consistent ideological orientation.

The third perspective presented two descriptive sub-studies of nurses work with patients suffering from affective disorder. In the first sub-study, a group of 14 nurses participated in a structured interview, aimed at identifying the content and rationale of 'routine nursing care' on the ward which was to be the base for the implementation of the major (experimental) study, described in Part Three of the thesis. The responses to these interveiews were used to develop two scales which were adminstered to the same subjects in an attempt to identify a) the clinical problems most commonly encountered and b) the nursing responses most commonly used on the ward. In the second sub-study a random sample of Scottish psychiatric nurses (n=61) provided self-report data on their interactions with depressed patients using Flanagan's (1954) critical incident technique. A total of 651 reports were analysed using the classification system developed by Cormack (1983).

In Part One, three specific questions were addressed. What role does the nursing literature describe in relation to patients suffering from affective disorder in general and manic depressive psychosis in particular? What are the explicit and implicit objectives of the

Registered Mental Nurse training programme in relation to the care of the patient with affective disorder in general and manic depressive psychosis in particular? How do practising nurses perceive their role when caring for the patient with affective disorder in general and manic depressive psychosis in particular? The interrelated sub-studies in Part One provided much information on nursing practice and the models and opinions which influence that practice. The focus of these studies was necessarily broad. In some cases, the care of all people with affective disorder was considered; in others, only patients with manic depressive psychosis. This broad perspective was considered necessary, given the confusion reported in the literature over the diagnosis of manic depressive disorder, and the assumption that many practices, relevant to the care of manic depressive patients, might be common to all people with affective disorder.

The training syllabus and the British nursing literature emphasised a supportive role for nurses which, in the analysis of the examination questions, favoured a 'medical expressive' nursing role. Nurses were primarily described as supporting, or facilitating, the treatment regimes of psychiatrists. In the training syllabus, the formal therapeutic role was defined in terms of supporting the psychotherapeutic input of clinical psychologists. In contrast, the nurses in the two clinical sub-studies emphasised their 'therapeutic relationships' with patients with affective disorder, largely to the exclusion of more physical aspects of nursing care, or to descriptions of their 'medical expressive' role. However, these therapeutic strategies were very generalised and failed to reflect any obvious

ideological persuasion. Given the developments which have taken place in nursing, especially over the past decade, the nursing literature and the training syllabus may best be seen as 'scene-setters', rather than clear determinants, or indices of contemporary nursing practice. By contrast, the two descriptive sub-studies reported may serve as more appropriate evaluations of contemporary practice. The nurses in these studies expressed a preference for 'therapeutic-nursing' but did not appear to anchor such approaches to any specific conceptual model of care of the person with affective disorder. Despite differences among the data emerging from these various examinations of the training, reported practice and perceived role of the psychiatric nurse, certain common features were evident. The main emphasis common to all three perspectives was the provision of *support* to the patient suffering from affective disorder, within the context (mainly) of *individual relationships*, in an environment which emphasised the *promotion of everyday self-care, social and recreational activities*, within which specific medical treatments were introduced, for which the nurse assumed some responsibility, in terms of their adminstration and acceptance by the patient. This basic description was accepted as an adequate, though not exhaustive, definition of the concept of 'routine nursing care' as it related to the patient with affective disorder.

The patient with manic depressive psychosis' view of herself

In Part Two, an attempt was made to describe manic depressive patients' view of themselves, from the perspective of social learning theory. A community based sample (n=44) was studied first, using two standardised measures of 'locus of control'. The results of this study challenged

the assumption that manic depressive psychosis represented a purely biological form of depression. Even in remission, the sample which had a history of depression only, differed significantly from a normative sample on the Social Reaction Inventory (Rotter, 1966). Patients with a history of depression and mania were not, however, significantly different from a normative sample on this measure. Both groups of subjects, however, showed differences from the normative sample on the Belief Survey (Reid & Ware, 1973). This measure also revealed between-group differences on the scale sub-scores. These findings suggest that manic depressive patients, *in remission*, project a psychological vulnerability, which may differ in character between subjects with a history of depression only and subjects with a history of depresssion and mania. Despite the burgeoning interest in the locus of control concept in recent years, the examination of patients with a history of manic depressive psychosis has been largely neglected to date. In view of the relative absence of complimentary studies, and the small scale of the study sample reported, the results of this survey require cautious interpretation.

A further sub-study was undertaken to develop a locus of control scale which measured the subjects view of herself as a sufferer from affective disorder. The DLCS (Depression Locus of Control Scale) was developed from structured interviewing and was tested for validity and reliability on a sample of pre-discharge and community based patients, both groups carrying the diagnosis of manic depressive psychosis. This scale showed significant differences between the subjects with a history of depression and mania, and those with a history of depression

only. This difference may, however, not have been clinically significant, given that the distribution of scores did not distinguish the groups on the basis of extremes of internality and externality. The value of this scale may well lie in its use as a short, reliable index of locus of control in relation to the patient's construction of herself as a vulnerable sufferer from chronic affective illness. The scale might best be used to monitor changes in locus of control across time which might indicate the adoption of a more 'positive', pragmatic attitude towards her situation as a 'chronic' sufferer from affective disorder. At a more speculative level, the scale might be used to determine which kind of care might best suit the patient. It could be argued that highly 'externalised' patients are like 'straws in the wind', susceptible to almost any environmental influence. It may be unrealistic to ask such patients to take much responsibility for self-change. A more structured, supportive care plan, such as the Modified Cognitive Therapy intervention described in Part Three, might be more appropriate. Alternatively, highly 'internalised' subjects, who within the context of affective disorder might be represented by the person with severe guilt, might benefit better from a care plan which allows her to make her own initiatives towards self-change, learning from her own mistakes and successes.

The effects of nursing intervention

In Part Three, the main (experimental) study reported on the effects of three discrete nursing interventions used in the care of women suffering from manic depressive disorder. In Cormack's (1983) view, there existed very little information on what constituted *good*

psychiatric nursing "other than the opinions of patients, nurses and other well informed people" (p.183). He suggested that the time was right for psychiatric nursing to move away from descriptive research, towards more experimental studies which would seek to answer "which nursing performances relates to positive patient outcomes?"(p. 184). The reported study represents one of the few experimental studies undertaken in psychiatric nursing, and perhaps the only one to date, which has focussed upon the care of patients suffering from severe affective disorder.

A considerable body of epidemiological research has shown that at least twice as many women as men suffer from depression. Other studies have suggested that this preponderance may reflect the distinguishing characteristics of female sufferers or their social situation. The possible status of women as a 'special case' suggested the need for a specific study of female sufferers. It is also acknowledged that some patients experience only one episode of affective disorder which, following effective treatment, is not repeated. In order to partial out the effects of such singular types of affective disorder, the study focussed solely upon women who had previously received treatment for an affective disorder.

The main (experimental) study compared three discrete patterns of nursing care. Routine Nursing Care (RNC) featured the supportive, medical expressive role described in Part One. Self Evaluation (SE) provided similar supportive, individualised attention, with an additional focus upon problem-solving using a simple self-monitoring

format. Modified Cognitive Therapy (MCT) used a structured format, based largely upon a modification of Beck's cognitive therapy approach (Beck *et al.*, 1980).

The results of the study suggest that the MCT group showed greater progress on some, though not all, of the dependent measures. The research hypotheses predicted significant differences between the groups, at discharge and at follow-up, predicting that the MCT group would show scores tending towards the norm in each case. Although no significant between-group differences were found at discharge, on any measure, follow-up comparisons lent support to one of the research hypotheses:

Reasearch Hypothesis 2 predicted that the MCT group would yield lower BDI scores than the RNC or SE group at follow-up. Significant differences between the three groups were found at follow-up, the MCT group showing lower BDI scores than either RNC or SE.

In the absence of significant difference between groups, all other null hypotheses were not rejected.

As noted above, the Beck Depression Inventory scores were significantly more improved at follow-up for the MCT group. This group also showed no relapses at six-months, whereas a total of five subjects from the other two groups had been readmitted prior to the follow-up. The MCT group also showed positive changes in ATQ 30 and the DLCS scores, across the three stages of the study and between admission and follow-up scores. The MCT group also showed more clinically significant changes on the

ATQ30 and DLCS, although between-group comparisons on these measures of 'clinically significant change' were statistically significant for the DLCS analysis only. All analyses of the Dysfunctional Attitude Scale data showed no difference between the groups and echoed similar findings from recent studies.

In the absence of significant between-group differences on the other uncontrolled variables measured (length of stay, age, number of previous admissions and drug treatment), there is strong support for the proposition that where differences existed between the groups, either on measures of statistical or clinically significant change, these changes reflected the superiority of the Modified Cognitive Therapy intervention over the Self Evaluation and Routine Nursing Care interventions. However, before discussing the possible meaning of the findings for nursing education and practice, a number of reservations concerning the study require discussion. These reservations relate to :

1. Diagnostic status of the subjects.
2. Possible role of socio-economic variables.
3. Use of objective measures of affective disorder.
4. Sample size.
5. Length of follow-up.
6. Use of the locus of control measure.

1. ***Diagnostic status of subjects.*** The possible methodological error of including subjects with a history of depression only in the same sample as subjects with a history of mania and depression, requires

consideration here. The removal of the sex variable, which appeared to figure prominently in various theoretical formulations of affective disorder, rendered the study sample homeogenous from that viewpoint. It can be argued that since all subjects met the criteria (Feighner *et al.*, 1972) of 'primary affective disorder : depression', the study sample was even more 'homogenous'. However, restriction of the sample to either unipolar (depression only) or bipolar depressed (mania and depression) subjects would have brought the sample characteristics into line with the recent recommendations of Kupfer and Rush (1983) and would have simplified the interpretation of the findings. Although, as noted above, the sample was restricted to subjects who had previous experience of affective disorder, there was some variation in the number of previous episodes of illness and treatment, the possible severity of previous illnesses and the timescale covering this history. Future studies might consider the value of restricting the research admission criteria to: patients with a minimum number of previous admissions, a documented history of affective disorder meeting a specific degree of severity, reported suicide attempts, or reports of suicidal intent.

Jablensky (1987) has noted that a variety of classificatory principles and criteria are used in the assessment of affective disorders. The Feighner criteria, Research Diagnostic Criteria (Spitzer *et al.*, 1977) and the DSM-III (American Psychiatric Association, 1980) dominate the American research scene. These criteria, Jablensky notes, are being "applied in an increasing number of European studies" (p.7). However, most European studies continue to use more traditional diagnostic

concepts: *endogenous* and *reactive* depression, *psychotic* and *neurotic* affective illnesses, these reflecting the ICD-8 and ICD-9 systems (World Health Organisation, 1978). The DSM-III still continues to generate considerable academic argument in the USA (Faust & Miner, 1986). However, this diagnostic system, with its emphasis upon highly descriptive, operationalised criteria, would provide future experimental nursing studies with a more objective basis for classification of subjects. Although the Feighner criteria used in the reported study are acceptable within academic circles, the author acknowleges that the DSM-III would provide similar future studies with a more stringent description of the patient sample.

2. Socio-economic variables. Brown and Harris' (1978) study of depression (*sic*) in women found that life events played a significant causal role in almost one half of their sample. The major role played by psychosocial factors is widely accepted now in relation to so-called *reactive depressions*. Bowlby (1985) suggested that such psychosocial factors might stimulate neurophysiological processes, which are then accepted as the *basis* of the depressive reaction. This view reinforces the opinion that disorders such as manic depressive psychosis *may* be a function of psychosocial and neurophysiologial processes. The reported study collected no data on the identifying socio-economic features of the subjects. No data were collected on life-events which might have precipitated admission. Subjects were classified initially according to age, number of previous admisions and diagnosis. During the study, length of stay and drug treatment was also monitored. Although these conditions were methodologically acceptable, it is recommended that

future experimental nursing studies should collect demographic data which might be used as an extension of diagnostic classification. Life events interview schedules (such as Paykel & Mangen, 1980) might provide a valid and reliable basis for such a classification of depressed subjects.

Bowlby's view also suggests the possible value of more comprehensive assessment of subjects, using if possible biological markers such as the Dexamethasone Test (Norman, Miller & Keitner, 1987) in association with psychological, behavioural and demographic data.

3. Objective measurement. All four measures of characteristics of affective disorder involved self-report ratings. Although a case was presented for the primacy of self-report in nursing research, the addition of objective measures would not have prejudiced the evaluation. In the reported study, objective measures were rejected for practical reasons. Future experimental research might consider the value of observational rating scales (Hamilton, 1967; Montgomery and Asberg, 1979) preferably adminstered by raters 'blind' to the interventions offered to the subjects. Given that three of the dependent measures of 'characteristics' of affective disorder in this study emphasised cognitive aspects, future studies might consider the inclusion of measures of non-cognitive features.

4. *Sample size.* The size of the sample (N=30) in the reported study requires the exercise of caution in the interpretation of the results. Although the selection and allocation procedure was acceptable, the

eventual size of the groups, for comparison purposes, was less than desirable. To some extent the size of the total sample was determined by the number of subjects who could be accomodated within the main (experimental) study at any one time. The main (experimental) study was delimited by the context of the treatment setting, where the treatment of non-research subjects was of equivalent priority. Future studies might consider larger samples by focussing upon follow-up, rather than upon in-patient care. In order to reduce the risk of making a Type I error, the significance level was set at .025 level for all one-tailed tests. The size of the three groups (n=10) may have reduced the likelihood that real between-group differences, on both the analysis of variance, and paired comparisons, were not detected. Alternatively, given the small sample size, the presence of significant differences on the between-groups comparison of the BDI at follow-up, and the paired comparisons on the ATQ30 and DLCS, suggested very real differences between the groups.

5. Length of follow-up. Although at the time of the design of the study the six-month follow-up appeared to be acceptable, recent research recommendations indicate that periods of up to 18 months after discharge are required (*cf.* Kupfer and Rush, 1983). Future studies might consider the need for longer follow-up in an attempt to evaluate the maintenance of gains made during hospitalisation and the potential for relapse. Such a study could involve the combined efforts of hospital and community nursing staff.

Future follow-up studies involving the manic depressive population might also focus attention upon the patient's *view of treatment* and ability to *recognise and respond to signs of imminent relapse.* These two features may play a significant role in the precipitation of readmission. Joyce's (1985) study of bipolar patients suggested that those subjects who were more accepting of treatment (and consistently took their medication) *or* were sensitive to symptoms of relapse, were less likely to be readmitted. Joyce notes that those who were inconsistently took their medication could remain well by being sensitive to 'calling for help', whereas those who took their medication religiously needed little understanding of their condition and its treatment. These considerations could be integrated into any future long term follow-up evaluation.

6. *Locus of control.* The study of the 'remitting' subjects in Part Two, and the experimental sample in the main study, illustrated the use of the locus of control construct. Recently, other nurse researchers have begun to employ this construct in different ways to evaluate nursing services and patients use of psychiatric facilities (Hawkins, 1984). In the main (experimental) study, subjects were not distinguished by their admission locus of control scores. Future studies might consider allocating subjects to experimental groups on the basis of low or high scores. Subjects who present as highly internalised, in principle would assume high degrees of responsibility for their own behaviour, whereas highly externalised subjects attribute, in principle, control over their behaviour to the external environment. The hypothesis that internalised subjects benefit more from care which emphasises

individual responsibility, whereas externalised subjects benefit more from care which is structured and supportive, requires testing. This could be achieved by allocation of 'externals' and 'internals' to two such care groups, perhaps employing a cross-over design to allow more stringent comparison.

The Nursing Care of the Severely Depressed Patient

The findings of the main (experimental) study suggests that Modified Cognitive Therapy intervention was associated with more significant 'improvement' in depression at six-month follow-up, with no subjects from this group being readmitted, and significantly lower scores being recorded at follow-up on the Beck Depression Inventory. Although between-group differences were less clear on the other dependent variables characteristic of depression, the MCT group showed the most significant *clinical* gains across time on the ATQ30 and DLCS, and showed a statistically significant improvement in Christensen and Mendoza's Significant Change (SC) index on the DLCS. Although these findings do not immediately attest to the superiority of the MCT intervention, they suggest the possible limitations of more traditional approaches to care of the patient with manic depressive psychosis. In this section, consideration is given to the possible content of nursing care for this population: what do nurses need to do for patients suffering from manic depressive psychosis? This is followed by consideration of the possible development of a model of care for

this group of patients; how might nurses meet the needs of such patients? Finally, the possible impact of such considerations on psychiatric nursing will be considered; what kind of nurse might we become? All three of these questions have implications for psychiatric nursing education.

The needs of the patient.

Shanley's (1984) study of mental nurses indicated that between 84 and 90% of the nurses he sampled offered facilitative conditions to patients: that is, they were "inherently helpful". The main (experimental) study, reported in Part Three, focussed more attention upon *what* the three groups of nurses did *for*, *with* or *to* the patients in their care. In this sense, the study was concerned more with the definition of the *aims* of care, than with the description of nurse-patient relationships. Although no specific attention was paid to analysis of the relationship variables described by Shanley, and more recently Reynolds (1986), it was assumed that a positive relationship between nurse and patient represented the very foundation of these interactions (see Barker, 1982; 1985).

The provision of support. Although the descriptions of the nurse's role in Part One emphasised the importance of providing support to all patients, it addressed the possible significance of this role in the care of people suffering from affective disorder. Reservations about indiscriminate support, especially in the form of reassurance, were noted in Chapter 4, with particular reference to the writings of

psychotherapeutic theorists from distinct theoretical backgrounds, Arieti and Bemporad (1980) and Beck and his colleagues (Beck *et al.*, 1980). One, perhaps key, difference between the three experimental groups lay in the Modified Cognitive Therapy (MCT) group's emphatic eschewal of any form of open reassurance, in favour of encouraging the patient to manipulate her problems on a cognitive or emotional level. Care should be taken, however, not to interpret this attitude as a reflection of a care environment lacking in emotional security. Indeed, the MCT intervention may have offered an equally supportive relationship to the other two experimental care settings, by virtue of the nurse's consistent interpretation of the patient's problems, from the perspective of the cognitive model of depression. The patient was encouraged, from the outset, to view her depression as a meaningful response arising from life events both past and present, mediated by her thinking style. A description of this conceptual model, which was outline in Chapter 13, was offered to the patient at the beginning of the 'patient's manual' (see Appendix 19) and was reinforced by use of the visual aid 'flip-chart' (see Appendix 22). The 'solidity' of this conceptual framework may have alleviated the anxieties of many subjects who were bewildered by the experience of depression: one subject from the Routine Nursing Care group volunteered the comment regarding her recall of her admission: "I didn't know what was wrong with me. Still don't" (abstracted from the Patient Satisfaction [PSS] data).

Although the provision of support, as it is commonly practised in psychiatric nursing, should not be criticised, the context of 'general support' may, paradoxically, be too narrow. As noted above, support

may be present when the nurse re-interprets the patient's experience from a specific ideological perspective. This interpretation serves as the basis for further exploration of the patient's experience. The MCT group nurses were requested to offer the patient consistent encouragement to *acknowledge* her feelings, identify what she was thinking and then to distance herself from both these 'experiences', by participating in a rational appraisal of her thoughts and feelings, accompanied by the nurse. This procedure, as Arnold (1960) noted, allows the patient an opportunity to *appraise*, and subsequently *reappraise* her experiences. This process could be viewed as a highly 'supportive' act. Perhaps more importantly, the nature of the MCT 'support' placed more emphasis upon taking action, rather than exploring the feelings. In this sense, the specific 'modified cognitive therapy' studied had some distinct parallels with Morita therapy, as noted in Chapter 13. Writing of the 'typical' Morita patient (who is always described as a 'student', since he is in a learning situation) Reynolds (1984) comments:

> ...they feel and think a great deal and do very little. What needs to be done often is to sit and map out a plan of action. My students often need to be prodded to *find out about reality by acting on and in it (p. 34: italics added).*

In an even broader context, it could be argued that people suffering from affective disorder need to learn how to cope with the situations which might, hypothetically, have triggered the depressive episode. If the supportive milieu is restricted to the hospital ward or to other professional contacts, such as clinics, or domiciliary visits, the patient may only receive a short-term 'buffering' from a stressful

environment. Mitchell and Moos (1984) suggested that although depressives (*sic*) were:

> ...often portrayed as the passive recipients of support from their surrounding network, in fact they are continuously in the process of making decisions that influence the shape and quality of their social ties (p.449).

The task for the carer, in Mitchell and Moos' view, is to help the depressive establish, sustain and utilize social support networks which will act as 'natural' buffers against the kinds of stress which trigger depressive breakdown. The relationship with the nurse might, therefore, be best seen as a 'rehearsal' for relationships in the patient's natural milieu: a rehearsal which might have more parallels with a theatre director and actor, or coach and sportsman, than with a 'healer' and 'sufferer'.

Personal development. It has long been acknowledged that some people with affective disorder exhibit deficiencies in social functioning, which might play a significant role in 'depressive' illness. Weissman *et al.* (1971) drew the conclusion that while women with a history of affective disorder were significantly more impaired than normal controls in all social roles, their greatest impairment lay in the area of intimate interpersonal relations, especially with husband and children. Although some researchers have focussed their attention exclusively upon the development of more effective social functioning for such patients (Bellack *et al.*, 1983; and Wells *et al.*, 1979) it could be argued that encouraging such patients to 'cope' better with interpersonal situations may prevent them from ever engaging in the appraisal-reappraisal process noted above. Although there is no

evidence in the form of documentary process data that the MCT nurses helped their subjects to appraise and reappraise areas such as 'intimate interpersonal relations', everyday problems such as anticipatory anxiety experienced before seeing her family at visiting time, and going home on pass were common problems in all three groups. As Sackeim and Wegner (1986) noted, the effectiveness of 'cognitive therapy' may lie not so much in promoting accurate self-appraisal, as "in encouraging the use of the types of cognitive distortion that characterises normal functioning"(p.559). In this sense, the aim of the Modified Cognitive Therapy interaction was to encourage the patient to be more 'realistic', by adopting some of the reasoning which 'normal people' use in order to be less self-critical or self-punitive.

The structure of care

Shanley's (1984) study, noted earlier in this chapter, investigated the prevalence of Roger's facilitative conditions, in a sample of psychiatric nurses. He emphasised the importance of such facilitative conditions, with a citation from Matarazzo (1977):

> ...so far we can probably safely say that psychological good health, flexibility, open-mindedness, positive attitudes towards people and interpersonal skills are associated with success as a psychotherapist (p.960).

It seems unlikely, though not impossible, that the differences between the three groups of patients in the experimental study were attributable to the deficiencies of Matarazzo's 'therapeutic qualities' in the RNC and SE group nurses. Instead, it is suggested that these differences were attributable to content differences of the three

interventions. The RNC intervention employed the open, flexible style of contact with the patient described in the literature and the reported descriptive studies. No specific therapeutic methods were employed and no distinguishing theoretical rationale was used to inform the patient of the aims or process of these interactions. The SE intervention was more structured by virtue of its use of the 'self-monitoring' format. However, no specific rationale was employed as an adjunct to these problem-solving sessions and no specific techniques were included in the definition of the intervention. By contrast, the MCT intervention was highly structured and employed a range of techniques, against the background of a theoretical rationale, which was articulated in the manual, and reinforced visually in the 'flip-chart' and other visual aids.

Hypotheses regarding the significance of the locus of control construct also have a bearing upon the role of support in care and therapy. Foon (1987) reviewed a number of studies which used locus of control scores as a determinant of therapy structure. Although her review indicated certain methodological weaknesses in some of the studies, there were clear indications that 'internalised' subjects responded best to therapies which were less 'directive' and viewed non-directive therapists positively. Alternatively, 'externalised' subjects reponded best to highly structured therapy, where the leader was very directive. Classification of the experimental sample in the main study as either 'externals' or 'internals' on the DLCS was difficult, due to the absence of normative data. All the indications are, however, that the sample's scores reflected moderate to high externality. If locus of

control represents the subject's interpretation of events (or construction of 'reality') then it could be hypothesised that the moderate to high levels of externality, parallelled the levels of depression reported by the sample. If 'depression' reflects a state of helplessness, as reported in Chapter 9, then it it seems plausible to assume that women who report feeling moderately to extremely depressed should also describe moderate to high 'externality' scores on a locus of control measure. By way of elaboration of the possible reasons for the superiority of the MCT group, discussed in Chapter 16, it could be hypothesised that the MCT subjects benefitted from the provision of the structure and leadership which, as 'externals', they required. The RNC and SE groups, by contrast, were given little direction, within an open (RNC) or loosely structured (SE) context..

From this perspective, the popularity of the non-directive 'counselling' approach espoused by Shanley (1984), which is reflected also in much of the contemporary literature reviewed in Chapter 3, might be seen as antithetical to the needs of, at least, the severely depressed patient who scores high on externality. Although the MCT intervention was highly structured, this is not to say that it was inflexible. Indeed, in many of the interactions the patient was required to plan ways of using her new 'skills' or knowledge outside of the ward setting. The following example illustrates how one subject was encouraged to extend ideas acquired in the sessions to meet her needs outside of the hospital.

Elaine S. was discussing her problem of facing neighbours when she went home on pass, at the weekend. Her main worry was that when she went shopping in the local supermarket, she might meet someone who knew her and, more importantly, might know that she had taken an overdose which led to her admission. The nurse discussed her fears, the likely feelings and 'automatic thoughts' associated with this situation. Once the patient had identified her 'thinking errors' and produced some effective 'challenges' to her worrying thoughts, the nurse asked her to think how she could plan to use a similar approach if, or when, she encountered this situation. After a few minutes Elaine constructed this 'plan'. Her son had a football key ring, bought at a local store. Elaine decided that she would buy one of these for herself, paint it black with her son's model paints and attach the key ring to her purse. By way of explanation, Elaine told the nurse that:

> ...when I go into a shop I will feel this ball dangling from my purse. If I start to worry about people looking at me, or talking about me, the ball will help me 'catch' my negative thoughts. You see, this will remind me that my negative thinking is my 'ball and chain': it really pulls me down. If I want to learn to live again, I need to get rid of this ball and chain.

The nurse as therapist

The experimental study attempted to control extraneous variables which might account for significant changes in the patient. A number of possible 'explanations' for the apparent success of the MCT intevention were discussed in Chapter 16. Assuming that all the nursing interventions had the same broad aim - 'to help the patient overcome

her depression'- did the interventions differ, or did the study reflect differences between the nurses?

Karasu (1986) suggested that all psychotherapies are similar to the extent that they use some combination of affective experiencing, cognitive mastery and behavioural regulation as therapeutic change agents. Smith *et al.* (1980) suggested that *allegiance* to a specific 'school' or belief system appeared necessary for the confidence and identity of the 'therapist'. From their meta-analysis of the psychotherapies they concluded:

> ...if anything our findings warn against an eclecticism in practice that fails to differentiate into one type or other of psychotherapy. One of the paradoxes of psychotherapy ...may be that although all therapies are equally effective, one must choose only one to learn and practice (p.185)

This kind of 'allegiance' is contrary to a trend emerging in psychiatric nursing, which has been described weakly as the eclectic approach. Many nurses are being encouraged to examine a range of psychotherapeutic models, and models of mental disorder, in an attempt to select the appropriate approach to suit the needs of the individual patient. As noted in Chapter 5, a study undertaken by the author of the content of contemporary psychiatric nurse training curricula related to affective disorder (Barker, 1986), revealed that a wide range of theoretical models are being taught, often within the context of a single course. One college reported that RMN students were offered *theoretical perspectives* on depression which covered 'psychoanalytic theory', including coverage of Freud, Klein and Bowlby; 'cognitive theory': Beck- the Primary triad in depression; 'Psychodynamic theory' - Arieti and the provisional relationship; 'Sociolcultural theories'-

learning theory (sic)- Seligman - learned helplessness, social correlates (e.g.Brown and Harris); 'biological/medical theories and disorders of neurotransmitter-production and distribution/genetic studies. The college suggested that training for nursing care planning might include: supportive psychotherapy, gestalt techniques, transactional analysis, relaxation and meditation therapy, behavioural techniques, behaviour modification, social skills training (Lyttle, 1986). It is clear that the theoretical and practical curriculum summarised above, which was selected for illustration because it detailed the content specifically, not because the author necessarily disagrees with the content, is of obvious relevance to the understanding of the possible aetiology and resolution of affective disorder. However, attempts to 'orientate' nurse learners to such a wide range of theoretical concepts and practice skills not only may represent a near impossible task for the novice nurse, but may leave him with the kind of "marginal identity" described by Smith *et al.* (1980).With this consideration in mind, apart from the distinction drawn above between structured and unstructured therapies, differences may also have existed between nurses in the main (experimental) study who felt they were aligned to a discrete conceptual model (MCT) and those who were less certain of 'what' they were doing and 'why'. Note was taken in Chapter 3 of recent statements of intent by national nursing groups to realign psychiatric nursing along more psychotherapeutic lines, within the parameters of a social, rather than a medical, model of psychiatry (JCMHNO, 1986; PNAS,1986). Within the context of these two statements, it is assumed that the 'development' of psychiatric nursing will occur if, or when, nurses are offered a

broader-based training, which acknowldges the 'need' for a wide range of skills, informed by an equally wide range of theoretical models. Concern needs to be expressed, perhaps, that such 'promiscuous borrowing' might leave the novitiate aware of aetiological origins and therapeutic possiblities, but relatively groundless in terms of any meaningful 'technology' of care.

Some Reflections on the Context of Care

Throughout the thesis, the terms care, treatment and therapy have been used almost synonomously. In this section, some consideration is given to the meaning implicit in the term 'nursing care'.

The term *therapy* is derived from the Greek *therapeutike*, meaning the art of healing. Although originally meaning remedial action in both health and disease, we have accepted this more open definition only recently. Therapy has always been construed as meaning the treatment of sickness or disease, whether metaphorical or actual. Today, efforts are being made to define 'medical rehabilitation' in holistic terms, where healing means to make whole: returning the person to his previously unimpaired homeostatic self. In psychiatry, therapy has had more limited aims: the ease of suffering and distress. Such conservative interventions have been called palliative, looking often more like 'care' than 'cure'.

Nursing has not been seen as 'therapeutic' until recently: the therapeutic role has, generally, been assumed to be the preserve of doctors. In the review of the training syllabus in Chapter 5, the nurse

was described largely as a therapeutic 'support' to doctors and clinical psychologists. Some nurses, however, believe that the nursing role of women has always been therapeutic. The views of Colliere on this point were considered in Chapter 3. The concept of the nurse-as-therapist, noted above, and which was the focus of the main (experimental) study, is stimulated without doubt by the assumption that nursing *per se* is not therapeutic. The popular concept of the 'nurse-therapist' is of a specialist who caters only for certain classes of patient. Implicit in this view is the assumption that some patients cannot be 'treated' and must, therefore, be given *only* care. A consideration of the root of the term care may help us to escape form this distressing dichotomy.

The verb *nurse* can mean "to promote growth and development". Mothers who nurse their children enable the process of growth and development. Although fathers are rarely blamed for the obstruction of such growth, where any parent is seen to stifle the child's growth this practice is called, figuratively, *smothering*. If we wish to clarify the meaning of the term *care* we need look no further than our gardens. The gardener, or *nurseryman*, exercises serious attention, concern and protection over his plants. He *cares* by ensuring that the soil is irrigated and aereated, and that plants are exposed appropriately to the elements. His 'care plan' varies according to different plants, but each embraces the same broad aim: a good gardener is someone who promotes growth and development. The definition of care in this context is functional. It is not enought to talk to plants, to love plants, or to have caring feelings about plants. The meaning of care is expressed by the function

of the relationship. A good gardener will *rear* plants which will eventually need less care.

Within the context of the population suffering from affective disorder, *good* nursing care could be defined as 'the necessary conditions for the promotion of growth and development'. This approach has been called *trephotaxis* (Barker, 1987). Such care is not concerned to *heal* people, or otherwise make them *whole*. Instead it projects an ecological awareness: acknowledging the interaction of biological, cultural, social and personal 'selves' that are the person who is the patient (see Barker, 1985: Chapter 1). Helping people in this trephotaxic way involves identifying, and subsequently meeting, their 'needs'. The needs of some people with affective disorder appear, from the reviews and experiments reported here, to have three main facets, which reflect the dimensions of thought, feeling and behaviour:

1) a need to learn how to think in a manner which promotes 'normal', adaptive, everyday functioning,

2) a need to learn how to 'draw' satisfaction (or meaning) from her world and

3) a need to learn how to handle the slings and arrows of outrageous fortune.

Some people, like some plants, may have been damaged at some critical stage of development. They will bear the scars of these traumas which are unlikely ever to disappear completely. This does not mean, however, that growth and development, within the limitations of the trauma, cannot take place. Some of the considerations expressed above,

concerning the need for structure, support network and so on may reflect some of the characteristic features of *some* people with affective disorder, damaged by earlier experiences. It may be unrealistic to believe that these traumas can be erased, or that the person can be made whole. It may be more appropriate, instead, to devise care which takes account of these weaknesses, in order to promote the assets of the individual.

Conclusion and recommendations for future research

This study was concerned with a critical examination of a delimited, albeit important, area of psychiatric nursing. The design of the study aimed to isolate 'non-specific' variables , such as the nature of the nurse patient *relationship*, in an effort to evaluate specific kinds of nurse-patient *interaction:* that is discrete nursing interventions. Despite the focus of the main (experimental) study, the reciprocal interaction between specific (certain techniques) and non-specific variables (quality of nurse-patient relationship) was acknowledged from the outset. In the context of the value of making possible distinctions, through psychotherapeutic research, between 'specific' and 'non-specific' variables, Strupp has written:

> the future of psychotherapy should not lie with the isolation of 'specific' or 'non-specific' factors; rather we need to become more explicit about what we can do and what we cannot do; what, under ordinary circumstances, we may be able to do in two or three months and what might take several years; and what might be done to refine our understanding of therapeutic principles and their application (Strupp, 1986, p. 519).

The results of the main (experimental) study suggests that despite our assumption that nurses play an important part in helping patients suffering from major affective disorder there are indications that some

ways of trying to meet the needs of such patients may be less helpful than others. The inherent limitations of the study recommend caution in the interpretation and generalisation of these findings. It has been noted already in this Chapter that, in at least one study (Shanley, 1984), the capacity of the majority of psychiatric nurse sample to establish positive relationships with patients, has been demonstrated. Acting on this finding, it is suggested that future psychiatric nursing research should focus more specifically upon the identification of the 'needs' of specific patient groups, in an attempt to extend our appreciation of appropriateness and effectiveness of specific variables, in the manner of the limited outcome evaluation reported in the research project here.

Based upon the findings of the main (experimental) study and the sub-studies reported here, the following recommendations are made for future nursing research dealing with the affective disorder population in general, and people diagnosed as suffering from manic depressive psychosis in particular.

1. Acknowledgement has been made, periodically throughout the thesis, to the difficulty in attaining any clear consensus of opinion on the nature, origins and definition of affective disorder. Acknowledgement has also been made of the possible confounding effect of differences between subjects in the experimental sample, who were classified under the same, broad diagnostic criterion. Despite the failure of leading authorities on affective disorder to agree on a single classification system for 'depression' worldwide, current 'informed' thinking appears

to favour the use of the Diagnostic and Statistical Manual (DSM-III) as the most clearly operationalised, diagnostic classification system at our disposal. Use of this diagnostic system might resolve some of the confusion regarding the status of 'depressed' patients who present with suicidal intent, reports of hallucinations and delusions, agitation or retardation, among other clinical features.

It is recommended that future research with patients suffering from affective disorder should aim to classify the subjects by use of the DSM-III, in preference to an other research, or clinical, diagnostic system.

2. Acknowledgement was also made, in the discussion of the results of the main (experimental) study, to the possible role of socio-economic variables in the generation or maintenance of affective disorder.

It is recommended that future research with patients suffering from affective disorder should define the sample subjects in terms of standard demographic variables, and also assess the influence of recent life-events.

3. Consideration was also given, in Chapter 16, to the 'cognitive bias' of the measures of the dependent variables employed in the main (experimental) study.

In order to avoid unnecessary bias, it is recommended that future research with patients suffering from affective disorder should adopt

measures which provide reliable and valid measures of emotional, cognitive , behavioural and biological correlates of 'depression'.

4. The development of the Depression Locus of Control Scale (DLCS) was reported in Part Two and included the collection of normative data from a small, community based, 'remitting' group. In view of the acknowledgement that locus of control is not a fixed trait, but an interpretation of the subject's reality liable to possible change, normative data should be collected from larger samples of both acutely ill and recovered patients with affective disorder, in order to provide meaningful comparison groups in further studies using this scale.

It is recommended that normative data be collected on the DLCS, with both male and female samples, a distinction being made between sample subjects who are being tested at an 'acute' phase of an affective illness and those who have 'recovered' or are otherwise 'in remission' from the illness.

5. Acknowledgement was made also of the hypothetical role of locus of control measures in determining the kind of care, therapy or support required by 'externalised' or 'internalised' subjects.

It is recommended that an experimental study should be designed to test the hypothesis that highly externalised subjects, on the DLCS, benefit from more directive or structured care; and that highly internalised subjects benefit from more autonomous forms of psychotherapy.

6. The main (experimental) study found no significant difference between the three groups in terms of drug treatment. However, the actual role of drugs in the recovery of the subjects remains unclear. If the period of 'asylum' and the interaction with the nursing staff played any part in the recovery of the subjects, then it can be assumed that the MCT intervention played a marginally more significant role in this respect.

It is recommended that a future research study should attempt to a) exert more control over the class and dosage of medication offered to subjects or b) attempt to arrange a drug-free trial of 'psychosocial' interventions, such as that described in the main (experimental) study.

7. Acknowledgement was made also, in Chapter 16, to the relative short time scale of the follow-up.

It is recommended that future experimental studies with patients suffering from any affective disorder should arrange follow-up evaluation measures on all subjects, including readmissions, at 12 and 18 months after discharge.

8. The description of the preperation for the main (experimental) study in Chapter 14 acknowledged that the nurses who applied the novel, MCT intervention received only 12 hours of training, prior to the study.

It is recommended that future research into studies of the effects of indepdent variables, such as MCT, should attempt to make comparisons

between staff with high levels of skill and knowledge, gained through either training or experience, and staff with more basic competencies.

9. The main (experimental) study sought to compare the effects of a very generalised form of 'helping', in Routine Nursing Care, with a more structured, yet largely atheoretical, care system in Self Evaluation. Both of these were compared with Modified Cognitive Therapy, which was highly structured and derived from a range of theoretical and technological backgrounds.

It is recommended that future research should compare specific 'models' of care, such as MCT, with other recognised psychotherapeutic systems (such as Rogerian counselling, or interpersonal psychotherapy) or nursing practices based upon discrete theories of nursing (such as Roy's adaption model).

10. The study reported the failure to obtain adequate Patient Satisfaction Scale data to complete the planned between-group analysis. Although some of the information obtained from the subjects who responded was of interest, the format used may not have focussed sufficiently upon the 'collaboration' between nurse and patient which might have distinguished the three types of intervention.

It is recommended that future research should define more clearly the nature of the 'working relationship' involved in caring for patients suffering from affective disorder, so that an evaluation can be made of the subjects response to different kinds of nursing intervention. Such

an evaluation should seek to clarify whether patients are able to distinguish between nurses who offer highly directive care, and from those who negotiate care goals and strategies with the patient. Such a study should seek, also, to evaluate the patient's attitude towards such differing care styles.

Epilogue

Reference was made in the opening lines of this thesis, to the relative infancy of the 'science' of psychiatry. In reviewing some of the models of care and treatment of one of the oldest clinical populations in psychiatry, the person with depression or 'melancholia', it was apparent that the science of psychiatry has often made haste slowly. Although this practice may be frustrating to those of us who seek to have our darkness lightened, to the seeker after genuine enlightenment, 'not knowing' may constitute a source of knowledge in itself. In Chapter One passing reference was made also to the ancient status of descriptions of feeling or 'affectivity'. There it was noted that the progress of the last two thousand years may have provided us with an enrichened glossary of emotional terms, but the origins and perhaps function of such 'affectivity' is little clearer now than it was in Aretaeus' day. The experimental study, which formed the ultimate core of the research, traced its origins to the recent therapeutic innovation of 'cognitive therapy'. It may be significant that a new 'psychotherapy', which is best known for its attempts to redress the human imbalance found in affective disorder, should employ a concept of 'affectivity' which has changed little since the time of the ancient Greeks, namely that emotion is a consequence of thinking. It has not

been the aim of this thesis either to question or to reinforce such a concept; the intention was only to investigate this particular viewpoint, comparing it with other, less clear-cut projections of affective disorder.

The 'science' of psychiatry has, until comparatively recently, explored the human condition through (wo)man's reflections on the experience of happiness, sadness and so on. Much of our understanding of (wo)man is drawn from cultural sources, whether these involve mass reports by anthropologists and sociologists, or the more personalised reflections of writers and poets. All such information represents data sources which, with appropriate analysis and synthesis, can 'inform' the science of psychiatry and may hasten the elightenment. It seems only right and fitting to conclude this thesis, which has attempted to add to the 'scientific' knowledge base of psychiatric nursing, by reference to some literary data, which suggest that artists are just as prone to examine 'cognitive' variables and to attribute significance to thinking as a precipitant of emotional distress, as are psychiatrists, psychologists and sociologists.

The writings of Franz Kafka are widely accepted as metaphorical or symbolic statements depicting the powerlessness and frustrated despair of the depressive character. In Bemporad's (1980) view "Kafka's works permit a rare and unforgettable glimpse into the inner world of melancholia"(p.415). Kafka's biographer (Brod, 1973) describes the troubled childhood development of the young Kafka, against a background of family tragedy and a wholly unsatisfactory emotional relationship

with his father and mother which may have served as the base for his adult melancholy, disturbed by existential philosophical questions, the dilemmas of which are expressed in his writings. The 'cognitive theory' proposed by Beck (1976) attributes the origins of current negative thinking, such as that found in depressed patients, to certain dysfunctional 'schemas' or belief systems, whose origins lie in negative experiences of childhood and puberty. It is interesting to note, in respect of Beck hypothesis, that such a famous adult depressive as Kafka should write in a letter to his father, which recounts his early experiences and their lasting effect on his personality, that he found him to be all-powerful, critical and unfeeling; disparaging the very weakness he demanded in his son. The adult Kafka writes:

> In all my thinking I was, after all, under the heavy pressure of your personality...All these thoughts, seemingly independent of you, were from the beginning burdened with your belittling judgements (1973, p.23)

A no less hostile criticism of the influence of a parental figure, on the thinking style of the adult, is provided by the contemporary American humorist, Garrison Keillor. In his novel *Lake Woebegone Days* (Keillor, 1986) he enters a lengthy footnote, representing a verbatim transcript of a 'thesis', written by a fictitious member of his boyhood town, which details 95 critical statements made by the adult, of his mother and the effect of her parenting on his adult emotional self. In the final section of the 'thesis' the author writes of his mother :

> Now you call me on the phone to ask, "Why don't you ever call us?"...I didn't call because I don't need to talk to you any more. Your voice is in my head, talking constantly from morning till night. I keep the radio on, but I still hear you and will hear you

until I die, when I will hear you say "I told you so"(p.274).

If we were in any doubt that early childhood experiences, especially at the hands, or mouths, of a parent figure, played any part in the shaping of our view of ourselves and the world, then these two short quotations might dispel some of those doubts. For Kafka, the experience seemed to sour his whole adult experience, the bitterness unrelieved by his open expression of hostility towards his father. If the fictitious 'emotional cripple' in Keillor's book is the author himself, his humour is surely only a thin disguise for his outrage and protestations at the influence his mother's voice has upon his own thoughts and ultimately upon his emotional experience. Both writers remind us of the timeless quality of depressive experience and trace a line between contemporary emotional distress and early experience, which is threaded through the words with which we make sense of our world. As we seek to clarify our current confusion about the nature of affective disorder and its possible resolution, we should not forget that much of the understanding we seek may be found in the words of wise men and women, but may also be found in the expression of those who are entrapped by the experience we call 'affectivity'. In our striving to seek resolution for emotional pain we should not reject the hypothesis that, for some, such pain may be the inevitable sequelae of earlier life experiences. The aim of all our strivings may be to help the sufferer express what she experiences and then to learn ***how to do what needs to be done.***

LIST OF REFERENCES

Abramowitz S.I. (1969) Locus of control and self-reported depression among college students. ***Psychological Reports*** 25, 149-50.

Abramson L.Y., Seligman M.E.P. and Teasdale J. (1978) Learned helplessness in humans: Critique and re-formulation. ***Journal of Abnormal Psychology*** 87, 49-74.

Adler A. (1927) ***Practice and Theory of Individual Psychology.*** Harcourt, Brace : New York.

Albers R.J. (1977) Patient satisfaction : problems and prospects. ***POCA Press*** 11, 11-14.

Alladin W.J. (1975) ***Personality and cognition in depression: An empirical test of Beck's theory.*** M.Phil. dissertation. Goldsmith's College: London.

Aplher V.S. and Turkat I.D. (1986) Prediction versus reflection in therapist demonstrations of understanding: A replication with clinical cases. ***British Journal of Medical Psychology*** 59, 235-36.

Altschul A.T. (1963) Trends in psychiatric nursing. In H. Freeman and J.Farndale (eds) ***Trends in the Mental Health Services*** Pergamon : London.

Altschul A.T. (1972) ***Patient-Nurse Interaction : A study of interactive patterns on acute psychiatric wards.*** Churchill Livingstone : Edinburgh.

Altschul A.T. (1978) A systems approach to the nursing process. ***Journal of Advanced Nursing*** 3, 333-340.

Altschul A.T. (1984) Does good practice need good principles?: One. ***Nursing Times*** 80(28) 36-38.

Altschul A.T. (1985) There won't be a next time. Ch. 18 In V. Rippere R. Williams (eds) ***Wounded Healers : Mental Health Worker's Experiences of Depression.*** John Wiley : Chichester.

Altschul A.T. and McGovern M. (1985) ***Psychiatric Nursing : A Concise Nursing Text (6th Ed)*** Bailliere Tindall : London.

Altschul A.T. (1986) ***Foreword*** In J. Brooking (ed) ***Psychiatric Nursing Research*** John Wiley: Chichester.

Ambelas A. (1979) Psychologically stressful events in the precipitation of manic episodes. ***British Journal of Psychiatry*** 135, 15-21.

American Nurses Association (1980) ***Nursing*** (pamphlet). A.N.A.: Kansas City, Missouri.

American Psychiatric Association (1980) ***A Psychiatric Glossary*** APA: Washington DC.

Anderson B. and Nilsson S. (1964) Studies in the reliability and validity of the Critical Incident Technique. ***Journal of Applied Psychology*** **48**, 398-403.

Angst J. (1966) Zur atiologie und nosologie endogener depressiver psychosen. In ***Monographen aus der Neurologie und Psychiatrie.*** 112, Springer-Verlag: Berlin.

Anon. (1981) When the masquerade is over. ***Nursing Mirror*** 152 (19) 37-8.

Arieti S. (1980) In S. Arieti and J. Bemporad ***Severe and Mild Depression: the psychotherapeutic approach*** Tavistock : London.

Ariskal H.S. (1979) A biobehavioural approach to depression. Ch. 18 in R.A. Depue (ed) ***The Psychobiology of the Depressive Disorders*** Academic Press : New York.

Armitage P. (1986) The rehabilitation and nursing care of severely disabled psychiatric patients. ***International Journal of Nursing Studies*** 23(2) 113-123.

Arnold M.B. (1960) ***Emotion and Personality*** Columbia Press: New York.

Austin R. (1977) Sex and gender in the future of nursing. ***Nursing Times*** (Occasional Paper) August 25.

Ballinger C.B., Smith A.H.W. and Hobbs P.R. (1985) Factors associated with psychiatric morbidity in women - a general practice survey. ***Acta Psychiatrica Scandinavica*** 71, 272-280.

Barber P. (1986) The psychiatric nurse's failure therapeutically to mature. ***Nursing Practice*** 1(3) 138-141.

Barker P. (1982) ***Behaviour Therapy Nursing*** Croom Helm: London.

Barker P. (1983) ***Understanding your feelings...and solving your problems.*** Unpublished manuscript.

Barker P. (1985) ***Patient Assessment in Psychiatric Nursing*** Croom Helm : London.

Barker P. (1986) A study of the preperation of the RMN student for care of the patient with affective disorder. Unpublished manuscript.

Barker P. (1986) ***Defaulters and Non-compliance*** [Specialist adviser to the CASE programme]. Royal College of General Practitioners : London

Barker P. (1986) Keynote speech to the Psychiatric Nurses Association Conference, University of York, June 1986.

Barker P. (1987) 'Trephotaxis': the medium is the message. Unpublished manuscript.

Barker P. and Fraser D. (eds) [1985] ***The Nurse as Therapist : A behavioural model*** Croom Helm: London

Barker P., Hume A. and Roberson W. (1985) Psychological treatment in affective disorder. ***Nursing Mirror*** **160**(22) 34-36.

Barker P. and Wilson L. (1985) Behaviour Therapy Nursing : New wine in old bottles. ***Nursing Times*** 81(39) 31-34.

Barnes E. (1968) ***Psychosocial Nursing*** Tavistock Publications: London,.

Barret J., Oxman T. and Gerber P. (1987) Prevalence of depression and its correlates in a general medical practice. ***Journal of Affective Disorder 12, 167-74.***

Baumgart E.P. and Oliver J.M. (1981) Sex-ratio and gender differences in depression in an unselected population. ***Journal of Clinical Psychology*** **37**, 571-4.

Bebbington P.E. (1982) The course and prognosis of affective psychoses. In J.K. Wing and L. Wing (eds) ***The Handbook of Psychiatry*** **Vol.3** Cambridge University Press.

Bebbington P.E. (1985) Three cognitive theories of depression. ***Psychological Medicine*** **15**, 759-769.

Bebbington P.E., Hurry J., Tennant M ., Sturt E. and Wing J.K. (1981) Epidemiology of mental disorders in Camberwell. ***Psychological Medicine*** **11**, 561-79.

Beccle H.C. (1962) ***Psychiatry: Theory and Practice for Students and Nurses*** Faber and Faber : London.

Beck A.T. (1963) Thinking and depression. ***Archives of General Psychiatry*** **9**, 36-45.

Beck A.T. (1970) The core problem in depression : The cognitive triad. In J. Masseman (ed) ***Science and Psychoanalysis*** Grune and Stratton : New York.

Beck A.T. (1976) ***Cognitive therapy and the emotional disorders*** International Universities Press: New York.

Beck A.T. and Hurvich M. (1959) Psychological correlates of depression. ***Psychosomatic Medicine*** 21, 50.

Beck at., Ward C.H., Mendelson M., Mock J and Erbaugh J. (1961) An inventory for measuring depression. ***Archives of General Psychiatry*** **4,** 561-71.

Beck A.T. and Beamsderfer A. (1974) Assessment of Depression: The depression inventory. In P. Pichot (ed) ***Psychological Measurements in Psychopharmacology: Modern Problems in Pharmacopsychiatry*** Vol.7. S. Karger : Basle.

Beck A.T. and Greenberg R.L. (1974) ***Coping with depression*** Institute for Rational Living, Inc.: New York.

Beck A.T. and Greenberg R.L. (1974) Cognitive therapy with depressed women. In V. Franks and V. Burtle (eds) ***Women and Therapy: New psychotherapies for a changing society*** Brunner/Mazel : New York.

Beck A.T. Kovacs M. and Weissman A. (1975) Hopelessness and suicidal behaviour: An overview. ***Journal of the American Medical Association*** **234,** 1146-49.

Beck A.T., Rush A.J., Shaw B.F. and Emery G. (1980) ***Cognitive Therapy of Depression*** John Wiley: London.

Beck C.T. (1979) The occurrence of depression in women and the effect of the women's movement. ***Journal of Psychosocical Nursing and Mental Health Services*** 17(11) 14-16.

Belknap I. (1956) ***Human Relations in a State Mental Hospital*** McGraw Hill: New York.

Bellack A.S. , Hersen M., amd Himmelhoch J.M. (1983) A comparison of social-skills training, pharmacotherapy and psychotherapy for depression. ***Behaviour Research and Therapy*** 21(2) 107-117.

Belle D. (1982) ***Lives in Stress: Women and Depression*** Sage Pub.: Beverly Hills, Calif.

Bemporad J. (1980) In S. Arieti and J. Bemporad ***Severe and Mild Depression: The psychotherapeutic approach*** Tavistock: London.

Berrios G.E. (1985) The psychopathology of affectivity: conceptual and historical aspects. ***Psychological Medicine*** 15, 745-58.

Bertleson A., Harvald B. and Hauge M.A. (1977) Danish twin study of manic-depressive disorders. ***British Journal of Psychiatry*** 130, 330-51.

Bhanjii S. (1977) Treatment of depression by sleep deprivation. ***Nursing Times*** 73(15) 540-1.

Biegel A., Murphy D.L. and Bunney W.E. (1971) The manic-state rating scale: Scale construction, reliability and validity. ***Archives of General Psychiatry*** 25, 256-62.

Biley F. (1985) Learn to believe in yourself. ***Nursing Times.*** 81(22) 40-41.

Blackburn I.M., Loudon J.B. and Ashworth C.M. (1977) A new scale for measuring mania. ***Psychological Medicine*** 7(3) 453-8.

Blackburn I.M., Bishop S., Glen I. M., Whalley L.J. and Christie J.E. (1981) The efficacy of cognitive therapy in depression: A treatment trial using cognitive therapy and pharmacotherapy, each alone and in combination. ***British Journal of Psychiatry*** 139, 181-9.

Blaney P.H. (1977) Contemporary theories of depression: Critique and comparison. ***Journal of Abnormal Psychology*** 86, 203-223.

Bleuler E. (1906) ***Affektivitat, Suggestibilitat, Paranoia.*** Carl Marhold:

Saale. [Cited by Berrios op.cit.]

Blue R.F. (1978) Self-monitoring in the treatment of an acute mania. ***Psychological Reports*** **43,** 1256-8.

Bockoven J.S. (1963) ***Moral Treatment in Psychiatry*** Springer: New York.

Bonhoeffer K. (1910) ***Die symptomatischen psychosen im gefolge von akutem infektionem und innerem erkrankungen*** Leipzig: Deuticke (Cited by Arieti op. cit. p.5)

Bonime W. (1960) Depression as a practice. ***Comparative Psychiatry*** **1,** 194-8.

Bowen R.G., Rich R. and Schlotfeldt R.M. (1961) Effects of organised instructions for patients with the diagnosis of diabetes mellitus. ***Nursing Research*** 10(3) 151-9.

Bowlby J. (1985) ***Attachment and Loss: Volume 3 Loss, Sadness and Depression*** Pelican: Harmondsworth.

Braceland F.J. (1957) Kraepelin, his system and his influence. ***American Journal of Psychiatry*** **114,** 871.

Bradshaw P. (1986) Advocating change. ***Senior Nurse*** 5(1) 34.

Bratfos O. and Haug J.O. (1968) The course of manic-depressive psychosis. ***Acta Psychiatrica Scandinavica*** **44,** 89.

Bray R.E. and Bird T.E. (1964) ***The Practice of Psychiatric Nursing*** E and S Livingstone: Edinburgh.

Brewin C.R. (1986) Internal attribution and self-esteem in depression: A theoretical note. ***Cognitive Therapy and Research*** 10(4) 469-76,

Bridges P.K. and Bartlett J.R. (1977) Psychosurgery: yesterday and today. ***British Journal of Psychiatry*** **131,** 249-60.

Brockway B.F., Plummer O.B. and Lowe B.M. (1976) Effects of nursing reassurance on patients vocal stress levels. ***Nursing Research*** 25, 440-46.

Brod M. (1973) ***Franz Kafka: a biography*** Schocken Books : New York

Brown G.W. and Harris T. (1978) ***The Social Origins of Depression: A Study of Psychiatric Disorder in Women*** Tavistock : London

Brown M.M. and Fowler G.R. (1971) ***Psychodynamic Nursing : A Biosocial Orientation*** W.B. Saunders Co. : Philadeplhia

Bruch H. (1974) ***Learning Psychotherapy*** Harvard University Press : Cambridge, Mass.

Bryant J. (1983) Working on two losses ***Nursing Mirror*** 156(10) i-iii.

Burnard P. (1985) ***Learning Human Skills : A Guide for Nurses*** Heinnmann : London

Burns A. (1978) With a lot of help from my friends ***Nursing Mirror*** 146(20) 22

Burns D. (1980) ***Feeling Good: The New Mood Therapy*** William Morrow: New York

Burr J. and Andrews J. (1981) ***Nursing the Psychiatric Patient (4th Edition)*** Bailliere Tindall : London

Butler R.J. and Rosenthal G. (1978) ***Behaviour and Rehabilitation: Behavioural Treatment for Long-Stay Patients.*** Wright : Bristol

Butterworth C.A. (1987) Psychiatric Nursing : Fumbling in a vacuum or grasping at opportunity. ***Mental Health Nursing : The Journal of the Psychiatric Nurses Association*** October, p.6

Cadoret R.J. and Tanna V.L. (1977) Genetics of Affective Disorders In G. Usdin (ed) ***Depression*** Brunner/Mazel : New York

Campbell P. (1983) Coming through (Correspondence) ***Open Mind*** 4, p.15

Campbell W. (1979) The therapeutic community: Problems encountered by nurses. ***Nursing Times*** 75(47) 2038-40

Chaslin P. (1912) ***Elements de semiologie et de clinical mentale*** Asselinet Houzeau : Paris (cited by Berrios **op. cit.**)

Checkley S. (1986) Affective Disorder Ch. 12 In P. Hill (ed) ***Essentials of Postgraduate Psychiatry*** Grune and Stratton : London

Chesler P. (1972) ***Women and Madness*** Doubleday : New York

Christensen L.C. and Mendoza J. (1986) A method of assessing change in single-subject designs : An alteration of the RC index. ***Behaviour Therapy*** **17**, 305-8

Clayton P.J. (1978) Bipolar affective disorder : Techniques and results of treatment ***American Journal of Psychotherapy*** 32(1) 81-92

Cohen H.A. (1981) ***The Nurse's Quest for a Professional Identity*** Addison-Wesly Pub. Co.: Menlo Park, Calif.

Cohen M.B., Blake G., Cohen R.A., Fromm-Reichmann F. and Weigert E.V. (1954) An intensive study of 12 cases of manic-depressive psychosis ***Psychiatry*** **17**, 103-38

Coleman R.E. (1975) Manipulation of self-esteem as a determinant of mood of elevated and depressed women ***Journal of Abnormal Psychology*** **84**, 693-700

Coleman R.E. and Miller A.G. (1975) The relationship between depression and marital adjustment in a clinic population: a multitrait - multimethod study ***Journal of Consulting and Clinical Psychology*** **43**(5) 647-51

Colledge M. (1973) Cooling the mark out: A nursing function ***Nursing Times*** **69**(36) 1157-8

Colliere M.F. (1986) Invisible care and invisible women as health care providers *International Journal of Nursing Studies* 23(2) 95-112

Connolly J. (1856) *The treatment of the insane without mechanical restraint* Smith, Elder and Co.: London

Cook M.L. and Peterson C. (1986) Depressive irrationality *Cognitive Therapy and Research* 10(3) 293-8

Cooper W. (1978) Don't write us off as neurotics *Nursing Mirror* 147(24) 21-2.

Coppen A., Metcalfe M. and Wood K. (1982) Lithium Ch.9 In E. S. Paykel (ed) *Handbook of Affective Disorders* Churchill Livingstone : Edinburgh

Cormack D.F.S. (1976) *Psychiatric Nursing Observed* Royal College of Nursing: London

Cormack D.F.S. (1983) *Psychiatric Nursing Described* Churchill Livingstone : Edinburgh

Coryell W. and Winokur G. (1982) Course and Outcome Ch.7 In E.S. Paykel (ed) *Handbook of Affective Disorders* Churchill Livingstone: Edinburgh

Coryell W. and Zimmerman M. (1987) Progress in the classification of functional psychoses *American Journal of Psychiatry* 144(11) 1471-74

Costello G. (1982) Social factors associated with depression: A retrospective community study *Psychological Medicine* 12, 329-39

Covi L., Lipman R.S., Derogatis L.R., Smith J.E. and Pattison J.H. (1974) Drugs and group psychotherapy in neurotic depression *American Journal of Psychiatry* 131, 191-8

Critchley M. (1986) Unkind cuts *The New York Review* April 24, 7-12

Cross F.L. and Livingstone E.A. (1983) ***Oxford Dictionary of the Christian Church (2nd Edition)*** Oxford University Press: Oxford

Crowne and Conn (1965) Personal communication. Cited by Rotter J. (1966) Generalised expectancies for internal versus external control of reinforcement ***Psychological Monographs : General and Applied*** *80(1) p.15*

Darcy P.T. (1984) ***Theory and Practice of Psychiatric Nursing*** Hodder and Stoughton : London

Darcy P.T. (1985) ***Mental Health Nursing Sourcebook*** Bailliere Tindall: London

Davenport Y.B., Ebert M.H., Adland M.L. and Goodwin F.K. (1976) Couples group therapy as an adjunct to lithium maintenance of the manic patient ***American Journal of Orthopsychiatry*** **47**, 495-502

Davis B. (1986) A review of recent research in psychiatric nursing In J. Brooking (ed) ***Psychiatric Nursing Research*** John Wiley: Chichester

Department of Health and Social Security (1972) ***Report of the Committee on Nursing*** HMSO : London

Department of Health and Social Security (1979) ***Report of the Committee of Enquiry into Mental Handicap Nursing and Care*** HMSO: London

Depue R.A. and Monroe S. (1978) Learned helplessness in the perspective of the depressive disorders: conceptual and definitional issues ***Journal of Abnormal Psychology*** **87**, 3-20

Dingwall R. (1979) The place of men in nursing In M. Colledge and D. Jones (eds) ***Readings in Nursing*** Churchill Livingstone : Edinburgh

Dobson K.S. and Shaw B.F. (1983) The stability of cognitive assessment in depression. Unpublished manuscript University of Toronto, Canada (cited by Eaves and Rush [1984] op.cit.]

Dohrenwend B.P., Shrout P.E., Egri G. and Mendelsohn S.F. (1980) Measures of nonspecific psychological distress and other dimensions of psychopathology in the general population ***Archives of General Psychiatry*** **37**, 1229-36

Drummond J. (1985a) Personal communication.

Drummond J. (1985b) Personal communication.

Drummond J. (1987) Personal communication.

Dudley M. and Stewardson I. (1984) Nursing care study: Behaviour modification. ***Nursing Mirror*** 158(21) 37-9

Dunn G. and Rosen B. (1982) When the family must change too. ***Nursing Mirror*** **155**(22) 28-9

Durham R.C. and Turvey A.T. (1987) Cognitive therapy versus behaviour therapy in the treatment of chronic generalised anxiety ***Behaviour Research and Therapy*** **25**(3) 229-34

D'Zurilla T.J. and Goldfried M.R. (1971) Problem solving and behaviour modification ***Journal of Abnormal Psychology*** **78**, 107-26

Eaves G. and Rush J.A. (1984) Cognitive patterns in symptomatic and remitted unipolar major depression ***Journal of Abnormal Psychology*** **93**, 31-40

Elkin I., Parloff M.B., Hadley S.W. and Autry J.H. (1985) NIMH treatment of depression collaborative research program ***Archives of General Psychiatry*** **42**, 306-16

Ellis A (1962) ***Reason and Emotion in Psychotherapy*** Lyle Stuart : New York

Ellis A (1973) Rational Emotive Therapy In R. Corsini (ed) ***Current Psychotherapies*** Peacock : Itasca, Illinois

Eysenck H.J. (1976) ***The future of psychiatry*** Methuen : London

Faugier J. (1985) Throwing down the gauntlet ***Nursing Times*** **81**(20) 63

Faugier J. and Reilly S. (1986) Taking time to talk ***Nursing Times*** **82**(18) 52-4

Faust D. and Miner R.A. (1986) The empiricist and his new clothes: DSM III in perspective ***American Journal of Psychiatry*** **143**, 962-7

Feighner J.P., Robins E., Guze S., Woodruff R.A., Winokur G. and Munoz R.(1972) Diagnostic criteria for use in psychiatric research ***Archives of General Psychiatry*** **26**, 57-63

Felman S. (1975) Women and madness : The critical phallacy ***Diacritics*** **5**, 2-10

Findlay-Jones R. (1981) Showing that life-events are a cause of depression : A review ***Australian and New Zealand Journal of Psychiatry*** **15**, 229-238

Flanagan J.C. (1954) The critical incident technique ***Psychological Bulletin*** **51**(4) 327-58

Foa E.B. and Kozak M.D. (1986) Emotional processing of fear : exposure to corrective information ***Psychological Bulletin*** **99**, 20-35

Foon A.E. (1987) Review: Locus of control as a predictor of outcome of psychotherapy ***British Journal of Medical Psychology*** **60**, 99-107

Fowler J. (1981) Ups and downs in the life of Betty ***Nursing Times*** **77**(4) 146-50

Fowlie H.C. and Stokes R.F. (1972) ***Psychiatry in Comprehensive Nursing*** Collins : London

Fraser D., McLeod W.L., Begg J.C., Hawthorne J.H. and Davis P. (1976) 'Against the Odds': The results of a token economy programme with long-term psychiatric patients. ***International Journal of Nursing Studies*** **13,** 55-63

Freud S. (1957) Mourning and melancholia [orig. 1917] ***Standard Edition 14, 243-58 Hogarth Press: London***

Frieze I.H. (1975) Women's expectations for and causal attributions of success and failure. In M.T.S. Mednick, S.S. Tangri and L.W. Haffman (eds) ***Women and Achievement*** John Wiley : London

Frost M. (1976) Manic depressive psychosis ***Nursing Times*** 72(1) 60-61

Fuchs C.Z. and Rehm L.P. (1977) A self-control behaviour therapy programme for depression ***Journal of Consulting and Clinical Psychology*** **45,** 206-15

Garber J., Miller S.M. and Abramson L.Y. (1980) On the distinction between anxiety and depression: perceived control, certainty and probability of goal-attainment. In J. Garber and M.E.P. Seligman (eds) ***Human Helplessness: Theory and Applications*** Academic Press: New York

Gartside G. (1980) Balancing body and mind ***Nursing Mirror*** 150(13) 31-2

Garvey M.J., Tollefson G.D., Mungas D. and Hoffman N. (1984) Is the distinction between situational and nonsituational primary depression valid? ***Comprhensive Psychiatry*** 25(3) 372-5

Gelfand D.M., Gelfand S. and Dobson W.R. (1967) Unprogrammed reinforcement of patients behaviour in a mental hospital ***Behaviour Research and Therapy*** **5,** 201-7

General Nursing Council for Scotland (1962) Guide to the syllabus of subjects for psychiatric nurses. G.N.C.(Scot.): Edinburgh

Gibson H.B. (1974) Morita therapy and behaviour therapy ***Behaviour Research and Therapy*** **12**, 347-53

Giles D.E. and Rush A.J. (1982) Relationship of dysfunctional attitudes and dexamethasone response in endogenous and non-endogenous depression ***Biological Psychiatry*** **17**, 1303-1314

Goktepe E.O., Young L.B. and Bridges P.K. (1975) A further review of the results of stereotactic subcaudate tractotomy ***British Journal of Psychiatry*** **126**, 270-280

Goodwin F.K. and Zis A.P.C. (1979) Lithium in the treatment of mania ***American Journal of Psychiatry*** **129**, 44-7

Gordon V. (1986) Treatment of depressed women by nurses in Britain and the USA. Ch. 6 in J. Brooking (ed) ***Psychiatric Nursing Research*** John Wiley : Chichester

Gore P.M. and Rotter J.B. (1963) A personality correlate of social action ***Journal of Personality*** **31**, 58-64

Gough H. (1981) Manic depression: a token gesture ***Nursing Mirror*** **153**(8) 32-4

Gove W. and Tudor J. (1973) Adult sex roles and mental illness ***American Journal of Sociology*** **78**, 812-831

Gray E.G. (1983) Severe depression : A patient's thoughts ***British Journal of Psychiatry*** **143**, 319-322

Greenblatt M. (1977) Efficacy of ECT in affective and schizophrenic illness ***American Journal of Psychiatry*** **134**(9) 1001-5

Gregory W.L. (1981) Expectations for controllability, performance attributions and behaviour. In H.M. Lefcourt (ed) ***Research with the Locus of Control Construct (Vol. 1)*** Academic Press: New York

Group T.M. and Roberts J.I. (1974) Exorcising the ghosts of the Crimea *Nursing Outlook* 22(6) 368-72

Gruen G.E. and Ottinger D.R. (1969) Skill and chance orientations as determiners of problem-solving behaviour in lower- and middle-class children *Psychological Reports* 26, 83-104

Gunning R. (1952) *The technique of clear writing* McGraw-Hill: New York

Hamilton E.W. and Abramson L.Y. (1983) Cognitive patterns and major depressive disorder: a longitudinal study in a hospital setting *Journal of Abnormal Psychology* 92, 173-84

Hamilton M.A. (1967) Development of a rating scale for primary depressive illness *British Journal of Social and Clinical Psychology* 6, 278-96

Hamsher J.H., Geller J.D. and Rotter J.B. (1968) Interpersonal trust, internal-external control and the Warren Commission Report *Journal of Personality and Social Psychology* 9(3) 210-15

Handley S.L., Dunn T.L. and Baker J.M. (1977) Mood changes in pueperium, and plasma tryptophan and cortisol concentration *British Medical Journal* 2(6078), 18-20

Harding J. (1981) The pharmaceutical industry as a public health hazard and as an institution of social control. In D. Coburn, C. D'Arcy, P. New and G. Torrance *Health and Canadian Society* Fitzhenry and Whiteside : Toronto

Harvey J.M. (1971) Locus of control shift in administrators *Perceptual and Motor Skills* 33, 980-82

Hathaway S.R. and McKinley J.C. (1943) *The Minnesota Multiphasic Personality Inventory* Psychological Corporation : New York

Hawkins L.L. (1984) The effect of negative affect and locus of control upon utilisation of mental health services ***Dissertation Abstracts*** **45, No.6**

Hein E.C. (1980) ***Communication in nursing practice*** Little Brown : Boston

Helm S.B. (1984) Nursing care of the depressed patient: A cognitive approach ***Perspectives in Psychiatric Care*** 22(3) 100-107

Henderson S., Duncan-Jones P., Byrne D.G., Scott R. and Adcock S. (1979) Psychiatric disorders in Canberra: a standardised study of prevalence ***Acta Psychiatrica Scandinavica*** **60,** 355-74

Henderson V. (1966) ***The Nature of Nursing*** Macmillan : New York

Henderson V. and Nite G. (1978) ***Principles and Practice of Nursing*** (6th edition) Macmillan: Mew York

Henderson V. (1986) Personal Communication.

Hollon S.D. and Kendall P.C. (1980) Cognitive self-statements in depression: Development of an Automatic Thoughts Questionnaire ***Cognitive Therapy and Research*** **4,** 383-98

Hopkins S. and Kumar R. (1985) An identity crisis ***Nursing Times*** **81**(34) 39-40

Horowitz M.J., Wilner N., Kaltreider N. and Alvarez W. (1980) Signs and symptoms of post-traumatic stress disorder ***Archives of General Psychiatry*** **37,** 85-92

Howell E. and Bayes M. (1982) ***Women and Mental Health*** Basic Books : London

Hsieh T.T., Shybutt J. and Lotsof E.J. (1969) Internal versus external control and ethnic group membership ***Journal of Consulting and Clinical Psychology*** **33,** 122-24

Hume A., Barker P. and Robertson W. (1984) The individual patient profile ***Nursing Times*** **80**(27) 56-9

Hussey T. (1979) Manic-depressive psychosis with rapid and profound changes of mood ***Nursing Times*** **75**(5) 193-5

Hutching S. (1987) A penny for your thoughts ***Open Mind*** **28**, 16-17

Information Services Division (1986) ***Scottish Health Statistics -1985*** Common Services Agency for the Scottish Health Service : Edinburgh

Ingram I.M., Timbury G.C. and Mowbray R.M. (1976) ***Notes on Psychiatry (4th edition)*** Churchill Livingstone : Edinburgh

Irving S. (1983) ***Basic Psychiatric Nursing (3rd Edition)*** W.B. Saunders Philadelphia

Jablensky A. (1987) Editorial: Prediction of the course and outcome of depression ***Psychological Medicine*** **17**, 11-9

Jacobsen E. (1954) The self and the object world ***Psychoanalytic Study of the Child*** **9**, 75.

Jacobson N.S., Follette W.C. and Revenstorf D. (1984) Psychotherapeutic outcome research: Methods for reporting variability and evaluating clinical significance ***Behaviour Therapy*** **15**, 336-52

James D. (1972) Trends in nurse education ***Nursing Times*** **68**(8) 29-31

Janowsky D.S., El-Yousef M.K. and Davis J.M. (1974) Interpersonal maneuvers of manic patients. ***American Journal of Psychiatry*** **131**, 250

Jenkins D.C. (1966) The semantic differential for health: A technique for measuring beliefs and diseases ***Public Health Reports*** **81**(6) 549-58

Johnson M.M. and Martin H.W. (1958) A sociological analysis of the nurse's role ***American Journal of Nursing*** **58**(3) 373-7

Joint Committee of Mental Health Nursing Organisations (1986) ***The Role of the Psychiatric Nurse*** JCMHNO : Manchester

Jones M. (1968) ***Social psychiatry in practice: The ideas of the therapeutic community*** Penguin : Harmondsworth

Joyce P.R. (1985) Illness behaviour and rehospitalisation in bipolar affective disorder ***Psychological Medicine*** 15,521-25

Kafka F. (1973) ***Letter to his father (orig. 1919)*** Schocken Books : New York

Kalkmann M. (1958) ***Psychiatric Nursing (3rd Edition)*** McGraw-Hill : New York

Kalman T.P., Talon N.S., Frances A. and Kocsis J.H. (1982) A controlled study of satisfaction among psychobiology research patients ***American Journal of Psychiatry*** 139(3) 344-7

Karasu T.B. (1986) The specificity versus nonspecificity dilemma: Toward identifying therapeutic change agents ***American Journal of Psychiatry*** 143(6) 687-95

Kazdin A.E. and Wilcoxon L. (1976) Systematic desensitisation and non specific treatment effects ***Psychological Bulletin*** 83, 729-55

Keillor G. (1986) ***Lake Woebegone Days*** Faber and Faber : London

Kelly G. (1955) ***The psychology of personal constructs*** Norton : New York

Kendell R.E. (1969) The classification of depressive illness: the uses and limitations of multivariate analysis ***Psychiatrica, Nosologica and Neurochirugia*** 72, 207-16

Kendell R.E. (1976) The classification of depressions: a review of contemporary confusion ***British Journal of Psychiatry*** 129, 15-28

Kendell R.E. (1983a) Diagnosis and classification In R.E. Kendell and A.K. Zeally ***Companion to Psychiatric Studies*** Churchill Livingstone : Edinburgh

Kendell R.E. (1983b) Affective psychoses In R.E. Kendell and A.K. Zeally ***Companion to Psychiatric Studies*** Churchill Livingstone : Edinburgh

Kennedy S., Thompson R., Stancer H.C., Roy A. and Persad E. (1983) Life events precipitating mania ***British Journal of Psychiatry*** **142,** 398-403

Kenney P. (1986) Open to interpretation ***Nursing Times Mental Health Nursing Supplement*** September 24, 3-5.

Kerlinger F.N. (1986) ***Foundations of Behavioural Research*** (3rd Edition) CBS Publishing Japan Ltd. : New York

Kershaw B. and Savage J. (eds) [1986] ***Models for nursing*** John Wiley : Chichester

Klein D.F. (1974) Endogenomorphic depression ***Acta Psychiatric Scandinavica*** **31,** 447-54

Klerman G.L., Dimascio A., Weissman M., Prusoff B. and Paykel E.S. (1974) Treatment of depression by drugs and psychotherapy ***American Journal of Psychiatry*** 131(2) 186-91

Klerman G. and Weissman M. (1980) Depression among women In M. Gutentag and D. Belle ***The Mental Health of Women*** Academic Press : New York

Klerman G.L. and Schecter G. (1982) Drugs and psychotherapy In E.S. Paykel ***Handbook of Affective Disorders*** Churchill Livingstone : Edinburgh

Klerman G.L., Weissman M.M. and Rounsaville B.J. (1984) ***Interpersonal Psychotherapy of Depression*** Basic Books : New York

Knowles R.D. (1981a) Handling depression through activity ***American Journal Nursing*** 81(6) 1187

Knowles R.D. (1981b) Coping with lethargy ***American Journal of Nursing*** 81(8) 1465

Knowles R.D. (1981c) Handling depression through positive reinforcement ***American Journal of Nursing*** 81(7) 1353

Knowles R.D. (1981d) Handling depression by identifying anger ***American Journal of Nursing*** 81(5) 968

Kovacs M., Rush A.J., Beck A.T. and Hollon S.D. (1981) Depressed outpatients treated with cognitive therapy or phramacotherapy : A one year follow-up ***Archives of General Psychiatry*** 38, 33-39

Kraepelin E. (1921) **Manic depressive insanity and paranoia** Livingstone: Edinburgh

Kupfer D.J. and Freedman D.X.(1981) Treatment for depression: Standard clinical practice as an unexamined topic ***Archives of General Psychiatry*** 43, 509-511

Kupfer D.J. and Rush A.J. (1983) Recommendations for scientific reports on depression ***American Journal of Psychiatry*** 140, 1327-28

Laing R.D. (1965) ***The divided self*** Penguin : Harmondsworth

Lamont J. (1972) Item mood-level as a determinant of I-E test response ***Journal of Clinical Psychology*** 28, 190

Lang P.J. (1979) A bioinformational theory of emotional imagery ***Psychophysiology*** 16, 495-512

Lefcourt H.M.(1977) ***Locus of control*** John Wiley : New York

Lefcourt H.M. (ed) [1981] ***Research with the locus of control construct 1 : Assessment Methods*** Academic Press : New York

Legget J. and Archer R.P. (1979) Locus of control and depression among psychiatric in-patients ***Psychological Reports*** **45**(3) 835-8

Leigh D. (1961) ***The historical development of British psychiatry : Vol 1 18th and 19th Centuries*** Pergamon Press : London

Levitt E.E., Lubin B. and Brooks J.M. (1983) ***Depression: Concepts, controversies and some new facts (2nd Edition)*** Lawrence Erlbaum Assoc.,Publishers : London

Lewin K. (1951) ***Field theory in social science*** Harper : New York

Lewinsohn P.M. (1974) A behavioural approach to depression In T.M. Friedman and MM. Katz (eds) ***The Psychology of Depression : Contemporary Theory and Research*** Winston : Washington

Lewinsohn P.M. and Amensen C. (1978) Some relations between pleasant and unpleasant mood related activities and depression ***Journal of Abnormal Psychology*** **87**, 644

Lewinsohn P.M., Mischel W., Chaplain W. and Barton R. (1980) Social competence and depression : The role of illusory self-perceptions? ***Journal of Abnormal Psychology*** **89**, 203-12

Lewis A. (1934) Melancholia: a historical review ***Journal of Mental Science*** **80**, 1

Lindsay M. (1983) The ogre of treatment ***Nursing Mirror*** **156**(10) iii-vi

Lloyd G. (1984) ***The Man of Reason : 'Male ' and 'Female' in Western Philosophy*** University of Minnesota Press : Minneapolis

Locke J. (1964) ***An essay concerning human understanding (orig. 1690)*** Fontana : London

Longhorn E. (1984) ***Psychiatric Care and Conditions*** (2nd Edition) John Wiley : Chichester

Lovett L.M. and Shaw D.M. (1987) Outcome in bipolar affective disorder after stereotactic tractotomy ***British Journal of Psychiatry*** **151,** 113-5

Ludwig A.M. and Ables M.F. (1974) Mania and marriage: The relationship between biological and behavioural variables ***Comprehensive Psychiatry*** **15**(5) 411-421

Lundquist G. (1945) Prognosis and course in manic depressive psychoses: A follow-up study of 319 first admissions ***Acta Psychiatric et Neurologica Scandinavica*** Supplement 35.

Lyttle J. (1986) Personal Comunication.

Macdonald M. (1981) ***Mystical bedlam: Madness, anxiety and healing in 17th century England*** Cambridge University Press: Cambridge

Macdonald N. (1982) Depression: an unhappy ending ***Nursing Mirror*** **154**(10) 45-7

Macdougall M. (1986) Personal communication.

Macilwaine H. (1981) How nurses and neurotic patients view each other in general hospital psychiatric units ***Nursing Times*** July 1st, 1158-60

Mahoney M.J. (1974) ***Cognition and behaviour modification*** Ballinger : Boston

Manderino M.A. and Bzdek V.M. (1986) Mobilising depressed clients ***Journal of Psychosocial Nursing and Mental Health Services*** **24**(5) 23-8

Marks I.M., Bird J. and Lindley P. (1978) Behavioural nurse therapists Developments and implications ***Behavioural Psychotherapy*** **6,**

Martin I.C. (1976) The case of christmas carol ***Nursing Times*** 72(51) 2005-6

Martin I.C. (1980) Clinical parable : many unhappy returns ***Nursing Times*** 76(30) 1319-21

Matarazzo R.G. (1977) Research on the teaching and learning of psychotherapy skills. In S.L. Garfield and A.E. Bergin (eds) ***Handbook of psychotherapy and behaviour change*** John Wiley : New York

Mayo J. (1979) Marital therapy with manic depressive patients treated with lithium ***Comprehensive Psychiatry*** 20(5) 419-26

McGivern D.O. (1972) The relationship between aggression in selected male surgical patients; satisfaction with hospitalisation; and attitudes of nursing personnel. Unpublished doctoral dissertation New York University

McGivern D.O. (1983) Personal communication.

McLean P. (1976) Therapeutic decision-making in the behavioural treatment of depression. In P.O. Davidson (ed) ***The behavioural management of anxiety, depression and pain*** Brunner/Mazel : New York

McLean P. and Hakstian A.R. (1979) Clinical depression: comparative efficacy of outpatient treatment ***Journal of Consulting and Clinical Psychology*** 47,818-36

McPherson F.M., Barker P., Hunter M.H. and Fraser D. (1978) A course in behaviour modification ***Nursing Times*** 74, 1207-9

Mead M. (1934) Kinship in the Admiralty Islands ***American Museum of Natural History - Anthropological Papers*** 34, 181-358

Melges F.T. and Bowlby J. (1969) Types of hopelessness in psychopathological processes ***Archives of General Psychiatry*** 20, 690-9

Mendels J. and Cochrane C. (1968) The nosology of depression: The endogenous-reactive concept ***American Journal of Psychiatry*** 124,1-11

Mendels J., Stern S. and Fraser A. (1976) Biological concepts of depression. In D.M. Gallant and G.M. Simpson (eds) ***Depression*** Spectrum Publishers : New York

Mental Health Act (Scotland) [1960] HMSO : London

Menzies I.E.P. (1961) ***The function of social systems as a defence against anxiety*** Tavistock Pamplet No.3 : London

Mereness D.A. and Taylor C.M. (1978) ***Essentials of Psychiatric Nursing*** (10th Edition) C.V. Mosby : St Louis

Meyer A. (1908) The problems of mental reaction - Types, mental causes and diseases ***Psychological Bulletin*** *5, 265.*

Miller W.R. and Seligman M.E.P. (1973) Depression and the perception of reinforcement ***Journal of Abnormal Psychology*** 82,62-73

Miller I.W. and Norman W.H. (1979) Learned helplessness in humans: A review and attribution theory model ***Psychological Bulletin*** 86, 93-118

Mindham R.H.S., Howland C. and Shepherd M. (1973) An evaluation of continuation therapy with tricyclic antidepressants in depressive illness ***Psychological Medicine*** 3, 5-17

Mitchell R.E. and Moos R.H. (1984) Deficiencies in social support among depressed patients : Antecedents or consequences of stress ***Journal of Health and Social Behaviour*** 25, 438-52

Mitchell R.G. (1986) ***Essential Psychiatric Nursing*** Churchill Livingstone : Edinburgh

Molinari V. and Khanna P. (1981) Locus of control and its relationship to anxiety and depression ***Journal of Person. Assess.*** 45(3) 314-9

Montgomery S.A. and Asberg M. (1979) A new depression scale designed to be sensitive to change ***British Journal of Psychiatry*** **134**,382-89

Moore M.S. (1975) Some myths about "mental illness ". ***Archives of General Psychiatry*** **32**, 1483-97

Moore T.W. and Paollilo J.G.P. (1984) Depression: influence of hopelessnes, locus of control, hostility and length of treatment ***Journal of Consulting and Clinical Psychology*** **54**, 875-81

Morris B. (1979) Depression : the midwife who wanted to die ***Nursing Mirror*** **149**(20) 20-21

Morrison J., Winokur G., Crowe R. and Clancy J. (1973) The Iowa 500: The first follow-up ***Archives of General Psychiatry*** **29**,678-82

Morton M.R. amd Tibbits J. (1970) Three years development of a new mental hospital as a therapeutic community ***Nursing Times*** **66**(18) 57-60

Murphy G.E., Simons K.D., Wetzel R.D. and Lustman P.J. (1984) Cognitive therapy and pharmacotherapy; singly and together in the treatment of depression ***Archives of General Psychiatry*** **41**, 33-41

Naylor G.J. (1984) Personal communication.

Naylor G.J. (1987) Personal communication.

Newmann J.P. (1984) Sex differences in symptoms of depression: Clinical disorder or normal distress? ***Journal of Health and Social Behaviour*** **25**, 136-59

Nightingale F. (1969) ***Notes on Nursing; What it is and what it is not*** Dover Pub. Co. Inc. : New York

Norman W.H., Miller I.W. and Keitner G.I. (1987) Relationship between dysfunctional cognitions and depressive subtypes ***Canadian Journal of Psychiatry*** 32(3) 194-8

Notman M. (1979) Midlife concerns in women : implications of the menopause ***American Journal of Psychiatry*** **136,** 1270-4

Palenzuela D.L. (1984) Critical evaluation of locus of control: Towards a reconceptualisation of the construct and its measurement ***Psychological Reports*** **54,** 683-709

Palmer R.D. (1971) Parental perception and perceived locus of control in psychopathology ***Journal of Personality*** 3,420-431

Parker G., Bradshaw G. and Blignault I. (1984) Dysfunctional attitudes: measurement, significant constructs and links with depression ***Acta Psychiatric Scandinavica*** 70,90-96

Parsons O.A., Schneider J.M. and Hansen A.S. (1970) Internal-External locus of control and national stereotypes in Denmark and the United States ***Journal of Consulting and Clinical Psychology*** 35,30-37

Paykel E.S., Prusoff B.A. and Uhlenhuth E.H. (1971) Scaling of life events ***Archives of General Psychiatry*** **25,** 340-47

Paykel E.S. and Mangen S.P. (1980) ***Interview for recent life events*** University of Cambridge, Department of Psychiatry

Paykel E.S. (1983) Methodolological aspects of life events research ***Journal of Psychosomatic Research*** 27(5) 341-52

Payne D.B. and Clunn P.A.(2nd Edition) [1977] ***Psychiatric-Mental Health Nursing*** Medical Examination Publishing Company : Flushing, New York

Pearson A. and Vaughn B. (1986) ***Nursing models for practice*** Heinemann Nursing : London

Peplau H. (1952) ***Interpersonal relations in nursing*** G.P. Putnam : New York

Peplau H. (1962) Interpersonal techniques: The crux of psychiatric nursing ***American Journal of Nursing*** **62,** 50-54

Peplau H. (1985) Personal communication.

Peplau H. (1986) Hildegard Peplau : Grande Dame of Psychiatric Nursing (interview) ***Geriatric Nursing*** **7**(6) 328-30

Peplau H. (1987) Interpersonal constructs in nursing practice ***Nursing Education Today*** **7,** 201-8

Perris C. (1966) A study of bipolar (manic depressive) and unipolar recurrent depressive psychoses ***Acta Psychiatrica Scandinavica*** Supp.194

Persons J.B. and Burns D.D. (1986) The process of cognitive therapy : The first dysfunctional thought changes less than the last one ***Behaviour Research and Therapy*** **24**(6) 619-24

Peterson R., Sushinsky 1. and Demask R.S. (1978) Are locus of control and depression related? ***Psychological Reports*** **43,** 727-31

Phares E.J. (1972) A social learning theory approach to psychopathology. In J.B. Rotter, J. Chance and E.J. Phares (eds) ***Application of a social learning theory of personality*** Holt, Rinehart and Winston : New York

Phares E.J. (1973) ***Locus of control: a personality determinant of behaviour*** General Learning Press: Morristown, New Jersey

Phares E.J. (1976) ***Locus of Control in Personality*** General Learning Press : Morristown, New Jersey

Pilowsky I. (1975) Dimensions of abnormal illness behaviour ***Australian and New Zealand Journal of Psychiatry*** **9,** 141-7

Porter A. (1970) Depressive illness in general practice: A demographic study and controlled trial of imipramine ***British Medical Journal*** 1, 773-8

Priest R.G. and Woolfson G. (1980) ***Minski's Handbook of Psychiatry for Students and Nurses*** Heinemann Medical Books : London

Psychiatric Nurses Association (Scotland) [1986] ***A proposal for change in RMN training*** PNAS : Dundee

Pullen I. (1979) Community nursing: when crisis hits the home ***Nursing Mirror*** 149(13) 30-32

Radloff L.S. and Rae D.S. (1979) Susceptibility and precipitating factors in depression: Sex differences and similarities ***Journal of Abnormal Psychology*** 88, 174-81

Ramon S. (1985) ***Psychiatry in Britain: Meaning and Policy*** Croom Helm : London

Reid D.W. and Ware E.E. (1974) Multidimensionality of internal versus external control: addition of a third dimension and non-distinction of self versus others ***Canadian Journal of Behavioural Science*** 6(2) 131-42

Rehm L.P. (1977) A self-control model of depression ***Behaviour Therapy*** 8, 787-94

Rehm L.P., Fuchs C.Z., Roth D.M., Kornbluth S.J. and Romano J. (1979) A comparison of self-control and social skills treatments of depression ***Behaviour Therapy*** 10, 429-42

Revely A. and Murray R.M. (1984) The genetic contribution to the functional psychoses Ch.2 In S. Crown (ed) ***Contemporary Psychiatry*** Butterworths : London

Reynolds D.K. Morita psychotherapy. In R. Corsini (ed) ***Handbook of innovative psychotherapies*** John Wiley : New York

Reynolds D.K. (1985) ***Playing ball on running water*** Sheldon Press : London

Reynolds W. (1985) Issues arising from interpersonal skills in Psychiatric Nurse Training. In C. Kagan (ed) ***Interpersonal Skills in Nursing Research and Application*** Croom Helm: London

Reynolds W. (1986) Personal communication

Reynolds W. (1986) A study of empathy in student nurses. MPhil. thesis Dundee College of Technology

Ribot T. (1897) ***The psychology of emotions*** Walter Scott ; London

Rice J. and Rice D. (1973) Implications of the women's movement for psychotherapy ***American Journal of Psychotherapy*** **130,** 191-5

Richardson M.W. and Kuder G.F. (1939) The calculation of reliability co-efficients based upon the method of rational equivalence ***Journal of Educational Psychology*** **30,** 681-87

Riehl J.P. and Roy C. (1980) ***Conceptual models for nursing practice (2nd Edition)*** Appleton-Century Crofts : New York

Rizley R. (1978) Depression and distortion in the attribution of causality ***Journal of Abnormal Psychology*** 87(1) 32-48

Rogers C.R. (1951) ***Client-centred therapy*** Houghton-Mifflin : Boston

Rosenbaum M. and Hadari D. (1985) Personal efficacy, external locus of control, and perceived contingency of parental reinforcement among depressed, paranoid and normal subjects ***Journal of Personality and Social Psychology*** **49**(2) 539-47

Rotter J.B. (1954) *Social learning and clinical psychology* Prentice Hall : Englewood Cliffs, N.J.

Rotter J.B. (1966) Generalised expectancies for internal versus external control of reinforcement ***Psychological Monographs : General and Applied*** **80**(1) 1-28

Round **N**. (1982) The big sleep ***Nursing Mirror*** **155**(13) 38-40

Rowe D. (1983) Helping the depressed patient ***Nursing Times*** **79**(43) 62-3

Roy C. (1976) Health-Illness (Powerlessness) Questionnaire. In ***Instruments for measuring nursing practice and other health-care variables (Vol.1)*** US Department of Health, Education and Welfare : Hyattsville, Maryland

Rush A.J., Beck A.T., Kovacs M. and Hollon S. (1977) Comparative efficacy of cognitive therapy and pharmacotherapy in the treatment of depressed outpatients ***Cognitive Therapy and Research*** **1**, 17-37

Rush A.J., Weissenburger J. and Eaves G. (1986) Do thinking patterns predict depressed symptoms? ***Cognitive Therapy and Research*** **10**(2) 225-36

Sackheim H. (1983) Self-deception, depression and self-esteem: The adaptive value of lying to oneself. In J. Masling (ed) ***Empirical Studies of Psychoanalytic Theory*** Lawrence Erlbaum Assoc. Inc. : Hillsdale, N.J.

Sackheim H. and Wegner A. (1986) Attributional patterns in depression and euthymia ***Archives of General Psychiatry*** **43**, 553-60

Sarnoff J. and Zimbardo P. (1961) Anxiety, fear and social affiliation ***Journal of Abnormal and Social Psychology*** **62**, 356-63

Saxton D.F. and Haring P.W. (1979) ***Care of patients with emotional problems*** C.V. Mosby : St. Louis

Schacter S. (1959) ***The psychology of affiliation*** Stanford University Press

Schacter S. and Singer J. (1962) Cognitive, social and physiological determinants of emotional state ***Psychological Review*** **69**, 379-99

Schafer R. (1948) **The clinical application of psychological tests** International Universities Press : New York

Schreiber M.T. (1978) Depressive cognitions ***American Journal of Psychiatry*** 135, 1570

Schwartz M.S. and Shockley E.L. (1956) ***The nurse and the mental patient : A study in interpersonal relations*** Russell Sage Foundation : New York

Scottish National Nursing and Midwifery Consultative Committee (1976) A new concept of nursing 1-3 ***Nursing Times*** April 8, 15, 22. Occasional Papers pp 49-60

Sedgwick P. (1982) ***Psycho Politics*** Harper and Row : New York

Seeman M. (1959) On the meaning of alienation ***American Sociology Review*** **24**, 782-91

Seigel S. (1956) ***Nonparametric statistics in the behavioural sciences*** McGraw-Hill : New York

Seligman M. and Maier S. (1967) Failure to escape traumatic shock ***Journal of Experimental Psychology*** **74**, 1-9

Seligman M. (1975) ***Helplessness: On depression, development and death*** W.H. Freeman and Co. : New York

Seligman M. , Abramson L.Y., Semmel A. and Van Baeyer C. (1979) Depressive attributional style ***Journal of Abnormal Psychology*** 88(3) 242-7

Shakir S.A., Volkmar F.R., Bacon S. and Pfefferbaum A. (1979) Group psychotherapy as an adjunct to lithium maintenance ***American Journal of Psychiatry*** **136,** 455-56

Shanley E. (1984) Evaluation of mental nurses by their patients and charge nurses. PhD. thesis University of Edinburgh

Shanley E. (1986) Personal communication.

Shapiro A. and Morris L. (1978) The placebo effect in medical and psychological therapies. In S. Garfield and A. Bergin ***Handbook of Psychotherapy and Behaviour Change*** John Wiley : New York

Shaw D.M., Kellam A.M.P. and Mottram R.F. (1982) ***Brain sciences in psychiatry*** Butterworths Scientific : London

Shaw R.L. and Uhl N.P. (1971) Control of reinforcement and academic achievement ***Journal of Educational research*** **64,** 226-8

Sheehan J. (1973) ***Essential psychiatry for nurses: A guide to important principles for nurses and laboratory technicians*** Medical and Technical Pub. Co. Ltd. : Lancaster

Shobe F.O. and Brion P. (1971) Long-term prognosis in manic-depressive illness ***Archives of General Psychiatry*** **24,** 334-7

Silverman S., Silverman J.A. and Eardley D.A. (1984) Do maladaptive attitudes cause depression? ***Archives of General Psychiatry*** **41,** 28-30

Simsen S. (1986) The spiritual dimension ***Nursing Times*** 82(48) 41-2

Skevington S. (ed) [1984] ***Understanding Nurses : The Social Psychology of Nursing*** John Wiley : Chichester

Smith M.L., Glass G.V. and Miller T.I. (1980) ***The benefits of psychotherapy*** Johns Hopkins University Press : Baltimore

Snell A. (1977) ***Mental disorder : An introductory text for nurses*** George Allen and Unwin : London

Speilberger C.D., Gorsuch R.L. and Lushene R. (1970) ***State-trait anxiety inventory manual*** Consulting Psychologists Press : Palo Alto, California.

Spitzer R.L., Endicott J., and Robins E. (1978) ***Research diagnostic criteria for a selected group of functional disorders (3rd Edition)*** New York State Psychiatric Institute : New York

Straiton H. (1986) Personal communication.

Strickland A. (1972) Delay of gratification as a function of race of the experimenter ***Journal of Personality and Social Psychology*** 22, 108-112

Stromgren L.S. (1973) Unilateral versus bilateral ECT: Investigations into the therapeutic effects in endogenous depression ***Acta Psychiatric Scandinavica*** Supplement 240, 8-65

Strupp H.H. (1986) The nonspecific hypothesis of therapeutic effectiveness : A current assessment ***American Journal of Orthopsychiatry*** 56(4) 513-9

Stuart G.W. and Sundeen S.J. (1979) ***Principles and practice of psychiatric nursing*** C.V. Mosby : St. Louis

Sugden J. (1986) Review of "Psychiatric Nursing": Wilson H.S. and Kneisl C. ***Psychiatric Nurses Association Focus*** May p.6

Sullivan H.S. (1947) ***Conceptions of modern psychiatry*** William A. White Psychiatric Foundation : Washington D.C.

Szasz T. (1962) ***The myth of mental illness*** Secker and Warburg : N.Y.

Taylor C.M. (1986) ***Mereness' Essentials of Psychiatric Nursing (12th Edition)*** C.V. Mosby : St. Louis

Teasdale J.D. and Fogarty S.J. (1979) Differential aspects of induced mood on retrieval of pleasant and unpleasant events from episodic memory ***Journal of Abnormal Psychology*** **88,** 248-57

Thompson R. (1980) Psychotherapy : A refined form of hell on earth ***Nursing Mirror*** **150**(10) 33-5

Topalis M. and Aguilera D.C. (1978) ***Psychiatric Nursing (7th Edition)*** C.V. Mosby : St. Louis

Towell D. (1975) ***Understanding psychiatric nursing*** Royal College of Nursing Research Series. RCN : London

Travelbee J. (1971) ***Interpersonal aspects of nursing*** (2nd Edition) F.A. Davis : New York

Trick K.L.K. and Obcarskas S. (1982) ***Understanding mental illness and its nursing (3rd Edition)*** Pitman : London

Tsaung M., Woolfson R. and Fleming J. (1979) Long-term outcome of major psychoses: Schizophrenic and affective disorders compared with a psychiatrically symptom-free surgical condition ***Archives of General Psychiatry*** **36,** 1295-1301

Tsaung M., Faraone S.V. and Fleming J. (1985) Familial transmission of major affective disorders: Is there evidence supporting the distinction between unipolar and bipolar disorders? ***British Journal of Psychiatry*** **146,** 268-71

United Kingdom Central Council (UKCC) [1987] ***Project 200 Report: A new preperation for practice*** UKCC : London

Valenstein E.S. (1986) ***Great and Desperate Cures : The rise and decline of psychosurgery and other radical treatments for mental illness*** Basic Books : New York

Valins S. and Nisbett R. (1972) Attribution processes in the development and treatment of emotional disorders. In E. Jones, D. Kanouse, H.Kelly, R. Nisbett, S. Valins and B Weiner (eds) ***Attributions : Perceiving the causes of behaviour*** General Learning Press : Morristown, New Jersey

Van Servellen G.M. and Dull L.V. (1981) Group psychotherapy for depressed women : A model ***Journal of Psychosocial Nursing and Mental Health Services*** 19(8) 25-31

Vousden M. (1986) Mental Health : Agents of change or care-givers? ***Nursing Times*** 82(26) 51-2

Walford-Kramer P. and Light H.K. (1984) Depression and mastery in women : Differences according to personal characteristics ***Psychological Reports*** 54(3) 710

Walk A. (1961) The history of mental nursing ***Journal of Mental Science*** **107, 1-17**

Wallston B.S. and Wallston K.A. (1973) Health care education programs : Training patient internality. Paper presented at the meeting of the American Public Health Association, San Francisco, November.

Wallston B.S., Wallston K.A., Kaplan G.D. and Maides S.A. (1976) Development and validation of the Health locus of Control Scale (HLC) ***Journal of Consulting and Clinical Psychology*** 44(4) 580-5

Walter C.J.S., Mitchel-Heggs N. and Sargant W. (1972) Modified narcosis, ECT and antidepressant drugs: A review of technique and immediate outcome ***British Journal of Psychiatry*** 120, 651-62

Ware E.E. (1964) Personal communication. Cited by Rotter J.B. (1966) op. cit.

Warheit G.J., Holzer C.E. and Schwab J.J. (1973) An analysis of social class and racial differences in depressive symptomatology: A community study ***Journal of Health and Social Behaviour*** **14,** 291-9

Watson O. (1976) ***Longman's Modern English Dictionary (3rd Edition)*** Longman : London

Watts A. (1978a) Depression : Why do people get the blues? 1: Assembling the jigsaw ***Nursing Mirror*** **147**(21) 32-3

Watts A. (1978b) Depression : Why do people get the blues ? 2: A biochemical explanation ***Nursing Mirror*** **147**(22) 40-1

Watts A. (1978c) Depression : Why do people get the blues? 3: What the nurse can do to help ***Nursing Mirror*** **147**(23) 41-2

Weissman M.M., Paykel E.S., Siegel R. and Klerman G.L. (1971) The social role performance of depressed women : Comparisons with a normal group ***American Journal of Orthopsychiatry*** **41**(3) 390-405

Weissman M.M., Klerman G.L. and Paykel E.S. (1974) Treatment effects on the social adjustment of depressed outpatients ***Archives of General Psychiatry*** **30,** 771-8

Weissman M.M. and Klerman G.L. (1977) Sex differences and the epidemiology of depression ***Archives of General Psychiatry*** **34,** 98-111

Weissman M.M. and Beck A.T. (1978) Development and validation of the dysfunctional attitudes scale. Paper presented at the meeting of the Association for the Advancement of Behaviour Therapy, Chicago.

Weissman .M.M. and Myers J.K. (1978) Rates and risks of depressive symptoms in a U.S. urban community ***Acta Psychiatric Scandinavica*** **57,** 219-231

Weissman **M.M.**, DiMascio A., Neu C., Goklaney **M.** and Klerman G.L. (1979) The efficacy of drugs and psychotherapy in the treatment of acute depressive episodes ***American Journal of Psychiatry*** **136,** 555-8

Wells K.C., Hersen **M.**, Bellack A.S. and Himmelhoch J.M. (1979) Social skills trining in unipolar nonpsychotic depression ***American Journal of Psychiatry*** **136,** 1331-32

Welner A., Welner Z. and Leonard M.A. (1977) Bipolar manic-depressive disorder: a reassessment of cause and outcome ***Comprehensive Psychiatry*** **18**(4) 327-32

Willey D. (1984) Only time will tell ***Nursing Mirror*** **158**(4) 42-5

Williams J.G., Barlow D.H. and Agras W.S. (1972) Behavioural measurement of severe depression ***Archives of General Psychiatry*** **27,** 330-3

Wilson A.R. and Krane R.V. (1980) Change in self-esteem and its effects on symptoms of depression ***Cognitive Therapy and Research*** **4,**419-21

Wilson-Barnett J. (1985) Key functions in nursing ***Lampada*** **2**(Winter) 35-9

Wilson-Barnett J. and Trimble **M.** (1984) Abnormal illness behaviour: the nursing contribution ***International Journal of Nursing Studies*** **21**(4) 267-78

Wing J.K. and Hailey A.M. (eds) [1972] ***Evaluating a community psychiatric service*** Open University Press : London

Wise T.N. and Rosenthal J.B. (1982) Depression, illness beliefs and severity of illness *Journal of Psychosomatic Research* 26(2) 247-53

World Health Organisation (1957) Seminar on the nurses in the psychiatric team. Norwiik, 4-15 November.

World Health Organisation (1978) ***Mental Disorders: Glossary and guide to their classification in accordance with the ninth revision of the International Classification of Diseases*** W.H.O. : Geneva

World Health Organisation (1979) ***Schizophrenia : The international follow-up study*** John Wiley : Chichester

Wright S.G. (1986) ***Building a model of nursing*** Edward Arnold : London

Zeiss A.M., Lewinsohn P.M. and Munoz R.F. (1979) Non-specific improvement effects in depression using interpersonal skills training, pleasant activity schedules or cognitive therapy *Journal of Consulting and Clinical Psychology* **45**, 427-39

Zilboorg G. (1941) ***A history of medical psychology*** Norton : New York

Zilboorg G. (1944) Manic-depressive psychoses. In S. Lorand (ed) ***Psychoanalysis Today*** International Universities Press : New York

Zimmerman M., Coryell W. and Corenthal C. (1984) Atttibution style, dexamethasone suppression test, and the diagnosis of melancholia in depressed outpatients *Journal of Abnormal Psychology* **93**, 373-77

Zung W.K. (1965) A self-rating depression scale ***Archives of General Psychiatry*** **12**, 63-70

Zuroff D.C. (1980) Learned helplessness in humans : An analysis of learning processes and the roles of individual and situational differences *Journal of Personality and Social Psychology* **39**, 130-46

APPENDICES

Appendix 1

Questions from the Registered Mental Nurse final examination: 1976 - 1985.

CODE

1. A middle- aged woman with a long history of manic-depressive psychosis has been re-admitted to hospital during a hypomanic episode.

   a) List the common physical and psychological features of hypomania.
   b) Discuss how the nurse should respond to the problems which can occur when establishing a relationship with this patient.
   c) Other patients become increasingly annoyed by her behaviour. Describe how you would deal with this situation.

2. A 52 year old man is admitted to hospital with hypomania.

   a) Outline the signs & symptoms that may be expected.
   b) Describe the nursing management during the acute phase.
   c) Indicate the specific nursing observations for this patient in relation to his lithium therapy.

3. A middle-aged man is admitted to hospital in an acute manic state.

   a) Describe the clinical manifestations of mania.
   b) Discuss the management of this condition.

4. A 40 year old woman with a severe depressive illness with psychotic features, is to have electro-convulsive therapy for the first time.

   a) Outline the clinical features likely to be present.
   b) Describe the psychological and physical preparation this woman will recieve.
   c) Describe the specific nursing care of the patient following ECT.

5. A patient in a hospital ward is suffering from acute mania.

   a) What observations would lead the nurse to suspect that this patient's physical condition was deteriorating?
   b) Describe the management of this patient's condition.

6. A middle-aged man with a diagnosis of mania is admitted to hospital.

   a) Describe the main signs & symptoms of mania.
   b) Describe the nursing management of this patient.

7. a) Describe the characteristic features of manic-depressive psychosis.
   b) Describe the nursing management of a patient who is in the depressed stage of this illness.

8. A patient with depressive illness, refuses to eat or drink.

   a) Consider possible reasons for the patient's refusal.
   b) What are the dangers of fluid imbalance?
   c) Describe in detail, how the nurse would ensure adequate nutrition.

9/...

CODE

9. A young woman suffering from acute mania is admitted to hospital.

   a) Describe the presenting features of this illness.
   b) What problems can arise during the admission procedure and how can they be minimised?
   c) Describe and explain the observations the nurse should report during the first few days following admission.

10. An elderly woman is admitted to hospital in a manic state.

   a) Describe the signs and symptoms of mania.
   b) Describe the nursing management of this condition.

11. A patient is admitted to hospital in a severely depressed state. ECT is prescribed.

   a) Describe the preparation of the patient for ECT.
   b) Discuss how the nurse may influence the outcome of this treatment.
   c) What special points have to be considered in the case of out-patients?

12. A young woman is admitted to hospital in a severely depressed state.

   a) Describe the clinical features of the patient's condition.
   b) Describe the medical and nursing management of this patient.

13. A middle-aged woman with a history of manic-depressive psychosis, is admitted in a depressive phase of illness.

   a) List the main symptoms of depression.
   b) Describe the nursing care of this patient.
   c) How should the patient be prepared psychologically for ECT?

14. a) What are the characteristics of psychotic depression.
   b) Describe the management and nursing care of a depressed patient in hospital.

15. A 30 year old man is admitted to hospital in a hypomanic phase of manic depressive psychosis.

   a) What are the characteristic features of hypomania?
   b) Discuss the nursing management of this patient.
   c) What action should the nurse take if the patient insists on discharge?

16. A patient overdoses on medication when she is in a severely depressed state.

   a) What may be the presenting signs and symptoms of severe depression?
   b) Describe the nursing management of the patient in hospital.
   c) Name two drugs used to treat depression, giving dosage and side effects.

17. A patient is admitted to hospital in a manic state.

   a) Describe the main signs and symptoms.
   b) Describe the nursing management of mania.
   c) How should the nurse deal with problems posed by visitors to the ward?

CODE

18. A 45 year old man is admitted to hospital in a hypomanic state.

    a) Describe the common clinical features of the condition.
    b) Discuss the nursing management of the patient in relation to:

        i) rest and sleep.
        ii) nutrition.
        iii) effect on other patients.

19. A depressed patient is refusing to eat or drink.

    a) Discuss the possible reasons for refusal.
    b) How would you cope with this problem?
    c) Discuss the important principles to be learnt from this situation.

20. a) Describe the preparation of the patient for ECT.
    b) Discuss the nurse's role during treatment.
    c) Discuss the care of the patient immediately following ECT.

21. A middle-aged man is admitted with recurrent mania.

    a) Describe the main symptoms of mania.
    b) Describe the role of the nurse in care and management.
    c) Name two medicines used to treat mania and identify their side effects.

22. A 45 year old man with manic-depressive psychosis is admitted in a hypomania state.

    a) Describe the symptoms at present and the symptoms likely to occur during a depressive phase.
    b) Discuss the patient's management in relation to diet and rest.
    c) How would you reassure the patient's wife who is distressed?
    d) Discuss the possible effect on other patients.

23. A patient is admitted with acute mania.

    a) Describe the signs and symptoms of mania.
    b) Describe the nursing care of the manic patient.

24. a) Describe briefly the use of lithium carbonate.
    b) What dosage of lithium carbonate is usally used and how is the dosage determined?
    c) Describe the effects of toxicity.

APPENDIX 2

Example of completed questionnaire used in preliminary definition of construct, routine nursing care.

Below are a number of questions about your role as a nurse in Ward 20.

Please give as much information as you wish.

A. Why do you believe that the establishment of a positive relationship is beneficial to that patient's welfare?

Establish early, an element of trust between nurse and patient. I believe, in general terms, if a patient develops confidence in staff's ability to help or alleviate symptoms, then obviously the patient will begin to benefit.

B. Why do you spend time talking to patients?

For observational purposes as well as establishing good nurse/patient relationship. Observation and questioning would allow one to find out if patient was hallucinating, deluded, anxious or suspicious. Answers given and assessment would be of help in care of treatment. Futher questioning asking about underlying causes of illness could produce answers to help in assessment.

C. Why do you think recreation is important?

For reaction, to assess ability of concentration and interaction with fellow patients and staff on a communal working basis. Also to stimulate interest and for general motivation to give the patient confidence that progress to health is possible.

D. What sort of information about the patient's condition do you normally collect?

General stresses or phobias and anxieties about their particular health, e.g. constipation. Home environment and general background. Family history with reference to personal relationships. Social and sexual behaviour. Details of the immediate period leading up to hospital admission.

E. What sort of information about the patient's condition do you normally give to the patient?

Mental conditions treated with support and reassurance. Questions answered truthfully, always remembering nothing to be said to deliberately aggravate the patient's condition. If after physical examinations and routine tests any abnormality is found, this would be explained to the patient in such a way as to alleviate any further distress.

F. What sort of information about her treatment do you normally give the patients?

This has been partially answered in question E, but chemotherapy or ECT treatment would be carefully explained. Also, if patient is suitable for MRU regime, this would be detailed.

G. What sort of information do you not disclose to the patient?

Confidential information that the Consultant or Ward Doctor has given to staff. Any serious illness or problem or death relating to members of immediate family, might be withheld.

H. Describe the different ways you go about giving information to a patient?

By taking the patient aside to the quietness of an interview room, is possibly the best way. There are occasions, however, when information can be given in a group situation.

L. What questions would you be asked by the patient?

These are innumerable, ranging from the very pressing to the trivial - training, common sense and experience, all combine to help one answer these as they come e.g

"When can I go out?", "When is visiting time?", "When can I have my hair washed?" "When can I have a cigarette?", "Will I ever get better?", "Will my home-life ever return to normal?"

There are, of course, a whole lot of social and sexual questions asked, too many and too obvious to be enumerated.

Patients regularly make demands upon your time. List below the things which the patient most often expects of you.
(Examples: conversation, information, help)

Patient asks for

1. A listening ear.
2. General conversation.
3. Support with worries or problems.
4. Information re - medication.
5. Information re - financial situation.
6. Information in general.
7. Reassurance that they will get better again.
8. Can you do my hair!

List below, the things which <u>you</u> most often do for the patient.

(Example: encourage problem-solving; discuss feelings).

<u>I give the patient</u>

Listen and give reassurance.

Help with any problems which may arise, if possible.

Encourage and help her maintain a standard of hygiene which she is used to.

To encourage her to take care of personal belongings and personal hygiene.

Maintain a degree of independence so that she does not become too reliant on the hospital.

APPENDIX 3

Definition of 'routine nursing' interactions: Rating Scale No. 1

Nurses use a wide range of interpersonal techniques in their dealings with patients. From the answers listed below, please indicate roughly <u>how often</u> you use these methods.

Please use the following scale to indicate this.

(A) Almost every day

(B) Once per week

(C) One per month

(D) Less than once per month

(E) Never

Please indicate your answer by using the letters (A) to (E). If any procedure seems inappropriate - put 'Not Applicable', e.g. N/A.

<u>EXAMPLE</u>

"Ask patient how she is feeling"	A
"Try to ignore disordered speech"	B
"Help her assess her anxiety"	N/A

Procedure

A) Converse on neutral topics to encourage normal conversation.

B) Try to alleviate the patients symptoms if she expresses them in conversation.

C) Approach patients in a direct manner if they look depressed, with for example the question "How are you feeling today?"

D) Make casual remarks to a given patient in a group setting to encourage a response in that patient.

E) Be supportive if a patient expresses feelings of anxiety by, for example, the reply "It's your nerves that are the problem."

F) Try to find out the root cause of a problem expressed by casual open ended questions.

G) Work on 'hunches', for example "She looks depressed, therefore she is depressed."

H) Actively 'listen' to every conversation with the patient.

I) If a patient appears indecisive, be supportive until a decision is made by the patient.

J) If the patient appears indecisive, give various alternatives in helping her to make a decision.

K) If the patient is indecisive, suggest what way you feel is the right way to tackle the problem presented.

L) Use your own values to influence the outcome of a problem-solving exercise.

M) If a patient expresses doubts about a given drugs use, would you say:-

   i) "Well, depression is caused by a chemical imbalance so it's worthwhile to keep taking the pills."

   ii) "Some drugs can be helpful and your doctor has prescribed these."

   iii) Discuss the pros and cons of continued use of the drug.

N/...

Procedure

N) If the patient lacks motivation, would you:

i) Find out through general conversation, what her likes are and capitalize on these interests.

ii) Ask her what she would like to do and if she does not come up with anything, suggest things for her to do.

iii) In the group setting suggest that the group do a certain activity and attempt in a subtle manner to involve her.

O) If she persists in remaining isolated, would you:

i) Draw back and pick another time to bring the subject of an activity up.

ii) Push the point to some extent with the view that persuasion which results in participation can be worthwhile.

iii) Draw back because her drugs may not have reached a therapeutic level at that time.

P) I would foster a good relationship with the patient in order to:-

i) Provide personal support.

ii) Gather information about the patient.

iii) Give the patient greater confidence in her own ability.

Q) If a patient asks "What is wrong with me nurse?", would you:-

i) Always give your honest view as to the cause of her condition.

ii) Ask more questions, then attempt to alleviate any worries she expresses without giving a straight answer.

iii) Refer her to a doctor telling the patient that he is the best person qualified to answer such a question.

iv) Say "Once your next blood results come through, we may know."

v) Refer her to another member of the nursing staff and let them deal with the request for information.

P /

Procedure

R) If the patient looks anxious, would you approach her by:-

i) Asking various questions related to her outward signs of anxiety before mentioning what you feel.

ii) Saying "You appear anxious, is something bothering you?"

iii) Engage the patient in general conversation and let the patient bring up the subject if she wishes.

iv) Find out what the problem is, then pass the information on to a doctor.

v) Find out what the problem is, then pass the information on to a senior nurse.

vi) Find out what the problem is, and attempt to deal with it yourself.

S) If you feel that the patient is expressing delusional thoughts, would you:-

i) Try to reason with her for a period of time.

ii) Acknowledge the patient's speech but do not pass comment on it.

iii) Spend time with the patient listening attentively because she is expressing these thoughts.

T) If the patient expresses suicidal thoughts to you, would you:-

i) Try to reason with her for a period of time, then report the matter.

ii) Acknowledge the patient's thoughts but do not pass comment. Then report the matter.

iii) Initially listen to what the patient has to say. Report the content of her thoughts, then return to discuss the matter with her to attempt to find a solution by working with her.

iv) After listening to the content, attempt to alleviate her symptoms.

APPENDIX 4

Definition of 'routine nursing' interactions: Rating Scale No. 2

The following is a list of problems shown by depressed patients.

Using the scale provided, please indicate roughly how often you deal directly with these problems.

Scale

(A) Almost every day

(B) Once per week

(C) One per month

(D) Less than once per month

(E) Never

Please indicate your answer by using letters (A) to (E)

Problem	A	B	C	D	E
1. Agitation					
2. Lack of motivation					
3. Poor concentration					
4. Poor personal hygiene					
5. Poor food intake					
6. Lack of communicative speech					
7. Delusional thoughts					
8. Immobility					
9. Suicidal ideas					
10. Tearfulness					
11. Lack of positive thoughts on future					
12. Lack of interest in appearance					
13. Unco-operative behaviour					
14. Feelings of guilt					
15. Attempted suicide					
16. Insomnia					
17. Constipation					
18. Hypochondrical ideas.					
19. Hallucinations					
20. Withdrawal					

APPENDIX 5

Letter to Directors of Nursing Services' inviting their participation in the drawing of the sample of nurses.

Affective Disorder

Nursing Research Project

Royal Dundee Liff Hospital
DUNDEE. DD2 5NF

[redacted]

Dear Colleague,

I am writing to ask for your help with part of a research project involving the study of the nursing care of patients suffering from severe affective disorder. You may have seen one of our recent publications which described one aspect of the project. A copy is enlosed for reference.

At present, I am trying to describe what nurses actually do for depressed patients. I hope to describe the range of activities, procedures and interactions which nurses engage in with their patients. To achieve this picture, I am asking nurses who work with this population to provide some information about what they do for, with or to their patients. This might range from "encouraging the patient to eat" to "preparing the patient for ECT". The nurse is left to decide which activities or interactions are important aspects of his/her care of the patient. There are no right or wrong answers.

To arrive at a realistic picture of nursing practice in this country, I have identified a list of hospitals which might supply information. The selection was made entirely at random to avoid bias in the information supplied. I have no idea of the kind of unit/hospital for which you are responsible.

So what do I want you to do? I would be most obliged if you would ask some of your staff, who work with depressed patients, to participate in the study. Again, to avoid bias, I would prefer you to ask specific people <u>at random</u>, rather than ask for volunteers: volunteers tend to be different from those who are conscripted. The only requirement is that they are RMN's. Anyone who agrees to participate will be anonymous: neither they nor the hospital will be identifiable. I will send them full details of what is required. They need only <u>list</u> things which they do routinely for their patients, on a prepared format.

I am asking Directors to 'nominate' staff to achieve a more representative picture of the typical pattern of care. If you are willing to ask any of your staff to nominate, please return the tear-off slip below, putting their names and ward/department addresses on the slip. I will then forward copies of the guidelines plus the prepared format to each nurse. I hope that you fill find the time to respond to this request.

Thanking you in anticipation.

[redacted]

Philip J. Barker — Clinical Nurse Consultant in Behaviour Therapy

Encs.

APPENDIX 6

Letter to the nurse participants in Critical Incident Survey.

Affective Disorder

Nursing Research Project

Royal Dundee Liff Hospital,
DUNDEE. DD2 5NF

[redacted]

Dear Colleague,

I have been advised by your Director that you are willing to assist us in our Research Project. In the part of the project with which I would like your help, I am looking at aspects of the nurse's work with depressed patients. This involves asking nurses like yourself to provide information about the kinds of interactions they have with depressed patients on a routine basis. I would like you to provide some simple details about the sorts of things you do 'with, for or to' depressed patients. I have enclosed a copy of the guidelines to which you should refer before beginning to make your notes. I have also included 30 recording sheets to use in the exercise. Please complete these and return them in the envelope provided at your earliest convenience.

If you have any queries about the task we have set out, please do not hesitate to contact me. I should like to thank you in advance for your assistance with this project. Your contribution will be greatly appreciated.

Yours sincerely,

Philip J. Barker
Clinical Nurse Consultant

Encs.

APPENDIX 7

The Critical Incident Record format

CODE _____

NAME _____

GRADE _____ DATE OF ENTRY _____

Describe an activity in which you did something for, to, or with, a patient (or his N.O.K.) which you believe represents **EFFECTIVE** nursing. Give your answer in the following parts.

A. What events led up to the activity?

_____

_____

_____

_____

B. What did you do (exactly) which seemed to be so EFFECTIVE?

_____

_____

_____

_____

C. Why do you believe the activity was EFFECTIVE?

_____

_____

_____

_____

D. Roughly, when did this activity take place?

_____

E. Indicate for which grade(s) of staff this activity is appropriate.

_____

_____

APPENDIX 8

Enclosure accompanying Critical Incident Records.

NURSING ACTIVITY WITH DEPRESSED PATIENTS

What is required

On the attached sheets we would like you to describe **any activity** which you believe represents an effective aspect of nursing care. This might involve doing things **for** the patient (such as brushing her hair) doing things **to** the patient (such as taking a blood sample) or doing things **with** the patient (such as discussing a problem or playing cards).

We impose no restrictions on the kind of entries you make. **You may describe any activity - however important or trivial it may appear.**

Please restrict your descriptions to work with depressed patients. By this, we mean anyone whose diagnosis involves depression in one form or another. Patients with bereavement problems, anxiety and depression, manic depressive psychosis, mixed affective states, endogenous depression or reactive depression, would all fit this description.

How to complete your description

Please try to make your entries as **explicit** as possible. Describe the "events leading up to the activity" by noting **exactly** what took place: e.g. record that the patient 'was **sitting crying** in the toilet' RATHER THAN 'the patient **appeared depressed**'.

Describe the acitivity which seemed to be EFFECTIVE in the same explicit manner. Describe WHAT YOU DID: e.g. 'I **put my arm round her** and aksed her if she wanted to talk' RATHER THAN 'I comforted her'.

Describe "why you believe the activity was EFFECTIVE" by explaining briefly the outcome of your action: e.g. "patient said 'thank you' and stopped crying", RATHER THAN "the patient settled down."

Indicate when this activity took place: e.g. "yesterday morning" or "last month". **The activities do not have to be current: i.e. today or yesterday.**

Indicate which grade of nurse might be able to offer the nursing care you have described. Some activities may be appropriate to certain staff, whereas others may be appropriate to any grade of nurse. **Please rely upon your own judgement.**

GOOD LUCK

Phil Barker

Research Director

APPENDIX 9

Rotter's I-E Scale: The Social Reaction Inventory

SOCIAL REACTION INVENTORY

Name: .....

Date: ..... Code: .....

This questionnaire is designed to find out how certain inpatient events affect different people. Each question has two alternatives, a or b: these represent different beliefs. Please choose the statement which you believe most strongly. Remember to pick the statement which you actually believe to be more true, rather than the one you think you should choose, or would like to be true. As the questionnaire is looking at personal beliefs, there are no right or wrong answers.

Please place a tick beside your answer, a or b, for each question on the inventory. Remember to put your name at the top of the page.

Read each statement carefully before you make your choice, but do not spend too long on any one item. Remember to answer every item.

In some cases you may believe both statements. In such cases pick the statement you more strongly believe to be the case. Try to answer each item separately: do not be influenced by your previous choices.

REMEMBER: Pick the alternative which you personally believe to be more true.

I more strongly believe that:

1. .....a. Children get into trouble because their parents punish them too much.
   .....b. The trouble with most children nowadays is that their parents are too easy with them.

2. .....a. Many of the unhappy things in people's lives are partly due to bad luck.
   .....b. People's misfortunes result from the mistakes they make.

3. .....a. One of the major reasons why we have wars is because people don't take enough interest in politics.
   .....b. There will always be wars, no matter how hard people try to prevent them.

4. .....a. In the long run people get the respect they deserve in this world.
   .....b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. .....a. The idea that teachers are unfair to students is nonsense.
   .....b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. .....a. Without the right breaks one cannot be an effective leader.
   .....b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. .....a. No matter how hard you try some people just don't like you.
   .....b. People who can't get others to like them don't understand how to get along with others.

8. .....a. Heredity plays the major role in determining one's personality.
.....b. It is one's experiences in life which determine what they're like.

9. .....a. I have often found that what is going to happen will happen.
.....b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. .....a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.
.....b. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. .....a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
.....b. Getting a good job depends mainly on being in the right place at the right time.

12. .....a. The average citizen can have an influence in government decisions.
.....b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. .....a. When I make plans, I am almost certain that I can make them work.
.....b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. .....a. There are certain people who are just no good.
.....b. There is some good in everybody.

15. .....a. In my case getting what I want has little or nothing to do with luck.
.....b. Many times we might just as well decide what to do by flipping a coin.

16. .....a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
.....b. Getting people to do the right thing depends upon ability; luck has little or nothing to do with it.

17. .....a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
.....b. By taking an active part in political and social affairs the people can control world events.

18. .....a. Most people can't realize the extent to which their lives are controlled by accidental happenings.
.....b. There is really no such thing as "luck".

19. .....a. One should always be willing to admit his mistakes.
.....b. It is usually best to cover up one's mistakes.

20. .....a. It is hard to know whether or not a person really likes you.
.....b. How many friends you have depends upon how nice a person you are.

21. .....a. In the long run the bad things that happen to us are balanced by the good ones.
.....b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. .....a. With enough effort we can wipe out political corruption.

.....b. It is difficult for people to have much control over the things politicians do in office.

23. .....a. Sometimes I can't understand how teachers arrive at the grades they give.

.....b. There is a direct connection between how hard I study and the grades I get.

24. .....a. A good leader expects people to decide for themselves what they should do.

.....b. A good leader makes it clear to everybody what their jobs are.

25. .....a. Many times I feel that I have little influence over the things that happen to me.

.....b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. .....a. People are lonely because they don't try to be friendly.

.....b. There's not much use in trying too hard to please people, if they like you, they like you.

27. .....a. There is too much emphasis on athletics in high school.

.....b. Team sports are an excellent way to build character.

28. .....a. What happens to me is my own doing.

.....b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. .....a. Most of the time I can't understand why politicians behave the way they do.

.....b. In the long run the people are responsible for bad government on a national as well as on a local level.

APPENDIX 10

Reid and Ware's Three-Factor Internal-External Locus of Control Scale: The Belief Survey

BELIEF SURVEY

Name: .....

Date: ..... Code: .....

This questionnaire measures personal belief: obviously there are no right or wrong answers. Each item consists of two alternatives (A) or (B). Pick the statment which you more strongly believe. Be sure to pick the statement you actually believe, and not the one you think you should choose, or would like to be true.

Please answer these items carefully, but do not spend too much time on any one item. Be sure to find an answer for every choice. Circle the letter of the statement (A or B) which you choose.

In some cases you may discover that you believe both statements or neither one. In such cases be sure to select the one you more strongly believe to be the case, as far as you are concerned. Also try to respond to each item independently when making your choice: do not be influenced by your previous choices.

1. (A) Various sports activities in the community help increase solidarity amongst people in the community.
   (B) Various sports activities in the community can lead to rivalry detrimental to the solidarity of the community.

2. (A) War brings out the worst aspects of men.
   (B) Although war is terrible, it can have some value.

3. (A) There will always be wars no matter how hard people try to prevent them.
   (B) One of the major reasons why we have wars is because people do not take enough interest in politics.

4. (A) Even when there was nothing forcing me, I have found that I will sometimes do things I really did not want to do.
   (B) I always feel in control of what I am doing.

5. (A) There are institutions in our society that have considerable control over me.
   (B) Little in this world controls me, I usually can do what I decide to do.

6. (A) I would like to live in a small town or a rural environment.
   (B) I would like to live in a large city.

7. (A) For the average citizen becoming a success is a matter of hard work, luck has little or nothing to do with it.
   (B) For the average guy getting a good job depends mainly on being in the
   (B) right place at the right time.

8. (A) Patriotism demands that the citizens of a nation participate in any war.
   (B) To be a patriot for one's country does not necessarily mean he must go to war for his country.

9. (A) In my case getting what I want has little or nothing to do with luck.
   (B) It is not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

10. (A) Sometimes I impulsively do things which at other times I definitely would not let myself do.
    (B) I find that I can keep my impulses in control.

11. (A) In many situations what happens to people seems to be determined by fate.
(B) People do not realize how much they personally determine their own outcomes.

12. (A) College students should be trained/in times of peace to assume military duties.
(B) The ills of war are greater than any possible benefits.

13. (A) Most people do not realize the extent to which their lives are controlled by accidental happenings.
(B) For any guy, there is no such thing as luck.

14. (A) If I put my mind to it I could have an important influence on what a politician does in office.
(B) When I look at it carefully I realize it is impossible for me to have any really important influence over what politicians do.

15. (A) With fate the way it is, many times I feel that I have little influence over the things that happen to me.
(B) It is impossible for me to believe that chance or luck plays an important role in my life.

16. (A) When I put my mind to it I can constrin my emotions.
(B) There are moments when I cannot subdue my emotions and keep them in check.

17. (A) Every person should give some of his time for the good of his town or country.
(B) People would be a lot better off if they could live far away from other people and never have to do anything for them.

18. (A) As far as the affairs of our country are concerned, most people are the victims of forces they do not control and frequently do not even understand.
(B) By taking part in political and social events the people can directly control much of the country's affairs.

19. (A) People cannot always hold back their personal desires; they will behave out of impulse.
(B) If they want to, people can always control their immediate wishes and not let these motives determine their total behaviour.

20. (A) Many times I feel I might just as well decide what to do by flipping a coin.
(B) In most cases I do not depend on luck when I decide to do something.

21. (A) Our federal government should promote the mass production of low rental apartment buildings to reduce the housing shortage.
(B) The best way for our government to reduce the housing shortage is to make low interest mortgates available and to stimulate the building of low cost houses.

22. (A) I do not know why politicians make the decisions they do.
(B) It is easy for me to understand why politicians do the things they do.

23. (A) Although sometimes it is difficult I can always willfully restrain my immediate behaviour.
(B) Something I cannot do is have complete mastery over all my behavioural tendencies.

24. (A) In the long run people receive the respect and good outcomes they worked for.
(B) Unfortunately because of misfortune or bad luck, the average guy's worth often passes unrecognized no matter how hard he tries.

25. (A) With enough effort people can wipe out political corruption.
(B) It is difficult for people to have much control over the things politicians do in office.

26. (A) Letting your friends down is not so bad because you cannot do good all the time for everybody.
(B) I feel very bad when I have failed to finish a job I promised I would do.

27. (A) By active participation in the appropriate political organisations people can do a lot to keep the cost of living from going higher.
(B) There is very little people can do to keep the cost of living from going higher.

28. (A) It is possible for me to behave in a manner very different from the way I would want to behave.
(B) It would be very difficult for me to not have mastery over the way I behave.

29. (A) In this world I am affected by social forces which I neither control nor understand.
(B) It is easy for me to avoid and function independently of any social forces that may attempt to have control over me.

30. (A) It hurts more to lose money than to lose a friend.
(B) The people are the most important thing in this world of ours.

31. (A) What people get out of life is always a function of how much effort they put into it.
(B) Quite often one finds that what happens to people has no relation to what they do, what happens just happens.

32. (A) Generally speaking, my behaviour is not governed by others.
(B) My behaviour is frequently determined by other influential people.

33. (A) People can and should do what they want to do both now and in the future.
(B) There is no point in people planning their lives too far in advance because other groups of people in our society will invariably upset their plans.

34. (A) Happiness is having your own house and car.
(B) Happiness to most people is having their own close friends.

35. (A) There is no such thing as luck, what happens to me is a result of my own behaviour.
(B) Sometimes I do not understand how I can have such poor luck.

36. (A) More emphasis should be placed on teaching the principles of Christianity in public school.
(B) Christianity should not be included in a school curriculum; it can be taught in church.

37. (A) Many of the unhappy things in people's lives are at least partly due to bad luck.
(B) People's misfortunes result from the mistakes they make.

38. (A) Self regulation of one's behaviour is always possible.
(B) I frequently find that when certain things happen to me I cannot restrain my reaction.

39. (A) The average man can have an influence in government decisions.
(B) The world is run by a few people in power and there is not much the little guy can do about it.

40. (A) When I make up my mind, I can always resist temptation and keep control of my behaviour.
(B) Even if I try not to submit, I often find I cannot control myself from some of the enticements in life such as overeating or drinking.

41. (A) My getting a good job or promotion in the future will depend a lot on my getting the right turn of fate.
(B) When I got a good job, it is always a direct result of my own ability and/or motivation.

42. (A) Successful people are mostly honest and good.
(B) One should not always associate achievement with integrity and honour.

43. (A) Most people do not understand why politicians behave the way they do.
(B) In the long run people are responsible for bad government on a national as well as on a local level.

44. (A) I often realize that despite my best efforts some outcomes seem to happen as if fate planned it that way.
(B) The misfortunes and successes I have had were the direct result of my own behaviour.

45. (A) Most people are kind and good.
(B) People will not help others unless circumstances force them to.

APPENDIX 11

Development of the Depression Locus of Control Scale: The structured interview format.

INTERVIEW QUESTIONS

Ask the following questions in the order indicated. Use a tape-recorder to record replies. Inform the patient that the tape will be wiped following analysis. Do not attempt to elicit answers if the patient is unwilling to answer. If she does not understand the question, you may re-phrase it.

1. How have you been feeling recently?
2. Can you tell me what you think was wrong with you at that time?
3. How long have you been like this?
4. What do you think is the main cause of your problems?
5. What makes you think that?
6. Apart from ... (the patient's response to 4 above) ... do you think that anything else might have caused your problems?
7. Some people think that they can control the way they feel: what do you think of that?
8. Have you had any upsets in your life recently?
9. What influence do they have upon how you feel?
10. Can you explain why you think that? (for either a YES or NO)
11. Do you ever feel really angry?
12. What about feelings of sadness?
13. Do you ever feel tense or anxious? (Is that in your head or body?)
14. Do you have other kinds of emotional problems?
15. Do you ever feel physically unwell - like can't sleep, or no appetite or aches and pains?
16. Do you ever feel you can't be bothered doing things?
17. Do you think a lot about your problems?
18. (If YES) Give me an example.
19. How do you think you get on with other people?
20. Is there anything else you would like to tell me about yourself?

Thank you very much for your time, you have been very helpful.

APPENDIX 12

The Consent Form

NURSING RESEARCH PROJECT

On this ward, we are carrying out a study of the work of the psychiatric nurse in caring for patients with various kinds of depressive illness. The aim of the study is to try to improve the skills of psychiatric nurses and, hopefully, to improve the quality of care they give to depressed patients. We should like to ask you to help us by taking part in this Project.

If you agree to help us, you will be asked to fill in some questionnaires. Apart from this, there will be no other 'extras' involved. The nursing staff will meet with you regularly to check upon your progress and to offer you various kinds of advice and assistance. However, this is routine practice on the ward.

If you agree to help us with this study, please sign the slip below for our records.

Thank you very much.

I have had the nursing research project explained to me and have read the above notes. I agree to take part in the Project. I am aware that I may withdraw from this Project at any stage.

Signed _____

Name _____

Date _____

Witness _____

APPENDIX 13

Letter to the ward Consultant Psychiatrist

TAYSIDE HEALTH BOARD
TAYSIDE AREA CLINICAL PSYCHOLOGY DEPARTMENT

1. Royal Dundee Liff Hospital, Dundee. DD2 5NF [redacted]
2. Strathmartine Hospital, Dundee. DD3 0PG [redacted]
3. Murray Royal Hospital, Perth. PH2 7BH [redacted]
4. Sunnyside Royal Hospital Hillside, Montrose. DD10 9JP [redacted]
5. Department of Child Psychiatry, Royal Infirmary, Dundee. DD1 9ND [redacted]

Your Ref.:

Our Ref.:

Enquiries to: P. BARKER Please reply to Address No.: 1 Date:

Nursing Research Project

Dear Dr Naylor

this is to inform you that the patient noted below has been selected for inclusion in the W.20 Nursing Research Project. I have recorded this in her nursing notes (NAPE) and will arrange to transfer scores on rating scales etc to our research files.

Name ..... Routine Nursing Care (RNC)
Modified Cog. Therapy (MCT)
Self Evaluation (SE)

[redacted]

APPENDIX 14

The Beck Depression Inventory (BDI).

THE BECK DEPRESSION INVENTORY (BDI)

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

Case Number: Name _____

1 2 3 4 5 6 Date _____

7 ( ) A.
0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

8 ( ) B.
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

9 ( ) C.
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

10 ( ) D.
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

11 ( ) E.
0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

12 ( ) F.
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

13 ( ) G.

0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

14 ( ) H.

0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

15 ( ) I.

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

16 ( ) J.

0 I don't cry anymore than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

17 ( ) K.

0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

18 ( ) L.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

19 ( ) M.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

20 ( ) N.

0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

21 ( ) O.
- 0 I can work about as well as before.
- 1 It takes an extra effort to get started at doing something.
- 2 I have to push myself very hard to do anything.
- 3 I can't do any work at all.

22 ( ) P.
- 0 I can sleep as well as usual.
- 1 I don't sleep as well as I used to.
- 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- 3 I wake up several hours earlier than I used to and cannot get back to sleep.

23 ( ) Q.
- 0 I don't get more tired than usual.
- 1 I get tired more easily than I used to.
- 2 I get tired from doing almost anything.
- 3 I am too tired to do anything.

24 ( ) R.
- 0 My appetite is no worse than usual.
- 1 My appetite is not as good as it used to be.
- 2 My appetite is much worse now.
- 3 I have no appetite at all anymore.

25 ( ) S.
- 0 I haven't lost much weight, if any, lately.
- 1 I have lost more than 5 pounds.
- 2 I have lost more than 10 pounds.
- 3 I have lost more than 15 pounds.

I am purposely trying to lost weight by eating less. Yes___No___

26 ( ) T.
- 0 I am no more worried about my health than usual.
- 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
- 2 I am very worried about physical problems and it's hard to think of much else.
- 3 I am so worried about my physical problems, that I cannot think about anything else.

27 ( ) U.
- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.

APPENDIX 15

The Automatic Thoughts Questionnaire (ATQ30).

ATQ30

Name: _____ Date: _____

Listed below are a variety of thoughts that pop into people's heads. Please read each thought and indicate how frequently, if at all, the thought occurred to you over the last week. Please read each item carefully and tick in the appropriate column on the answer sheet.

		Not at all	Sometimes	Moderately Often	Often	All the time
1.	I feel like I'm up against the world					
2.	I'm no good					
3.	Why can't I ever succeed?					
4.	No one understands me					
5.	I've let people down					
6.	I don't think I can go on					
7.	I wish I were a better person					
8.	I'm so weak					
9.	My life's not going the way I want it to					
10.	I'm so disappointed in myself					
11.	Nothing feels good any more					
12.	I can't stand this any more					
13.	I can't get started					
14.	What's wrong with me?					
15.	I wish I were somewhere else					
16.	I can't get things together					
17.	I hate myself					
18.	I'm worthless					
19.	Wish I could just disappear					
20.	What's the matter with me					
21.	I'm a loser					
22.	My life is a mess					
23.	I'm a failure					
24.	I'll never make it					
25.	I feel so helpless					
26.	Something has to change					
27.	There must be something wrong with me					
28.	My future is bleak					
29.	It's just not worth it					
30.	I can't finish anything					

APPENDIX 16

The Dysfunctional Attitudes Scale (DAS).

DAS

This Inventory lists different attitudes or beliefs which people sometimes hold. Read EACH statement carefully and decide how much you agree or disagree with the statement.

For each of the attitudes, show your answer by placing a checkmark (✓) under the column that BEST DESCRIBES HOW YOU THINK. Be sure to choose only one answer for each attitude. Because people are different, there is no right answer or wrong answer to these statements.

To decide whether a given attitude is typical of your way of looking at things, simply keep in mind what you are like MOST OF THE TIME.

EXAMPLE

Attitudes	Agree Strongly	Agree Slightly	Neutral	Disagree Slightly	Disagree Very Much
1. Most people are O.K. once you get to know them		✓			

Look at the example above. To show how much a sentence describes your attitude, you can check any point from "agree strongly" to "disagree very much". In the above example, the 'tick' at "agree slightly" indicates that this statement is somewhat typical of the attitudes held by the person completing the Inventory.

Remember that your answer should describe the way you think MOST OF THE TIME.

NOW TURN THE PAGE AND BEGIN

	Agree Strongly	Agree Slightly	Neutral	Disagree Slightly	Disagree Very Much
1. Criticism will obviously upset the person who received the criticism.					
2. It is best to give up my own interests in order to please other people.					
3. I need other people's approval in order to be happy.					
4. If someone important to me expects me to do something, then I really should do it.					
5. My value as a person depends greatly on what others think of me.					
6. I cannot find happiness without being loved by another person.					
7. If others dislike you you are bound to be less happy.					
8. If people whom I care about reject me, it means there is something wrong with me.					
9. If a person I love does not love me, it means I am unlovable.					
10. Being isolated from others is bound to lead to unhappiness.					
11. If I am to be a worth while person, I must be truly outstanding in at least one major respect.					

	Agree Strongly	Agree Slightly	Neutral	Disagree Slightly	Disagree Very Much
12. I must be a useful, productive creative person or life has no purpose					
13. People who have good ideas are more worthy than those who do not.					
14. If I do not do as well as other people, it means I am inferior.					
15. If I fail at my work then I am a failure as a person					
16. If you cannot do something well, there is little point in doing it at all					
17. It is shameful for a person to display his weaknesses					
18. A person should try to be the best at everything he undertakes					
19. I should be upset if I make a mistake					
20. If I don't set the highest standards for myself, I am likely to end up a second-rate person					
21. If I strongly believe I deserve something, I have reason to expect that I should get it					
22. It is necessary to become frustrated if you find obstacles to getting what you want					

	Agree Strongly	Agree Slightly	Neutral	Disagree Slightly	Disagree Very Much
23. If I put other people's needs before my own, they should help me when I need something from them.					
24. If I am a good husband (or wife), then my spouse is bound to love me.					
25. If I do nice things for someone, I can anticipate that they will respect me and treat me just as well as I treat them.					
26. I should assume responsibility for how people feel and behave if they are close to me.					
27. If I criticize the way someone does something and they become angry or depressed, this means I have upset them.					
28. To be a good, worthwhile, Moral person, I must try to help everyone who needs it.					
29. If a child is having emotional or behavioural difficulties, this shows that the child's parents have failed in some important respect.					
30. I should be able to please everybody.					
31. I cannot expect to control how I feel when something bad happens					
32. There is no point in trying to change upsetting emotions because they are a valid and inevitable part of daily living.					

	Agree Strongly	Agree Slightly	Neutral	Disagree Slightly	Disagree Very Much
33. My moods are primarily created by factors that are largely beyond my control, such as the past, body chemistry, or hormone cycles, or biorhythms, or change or fate.					
34. My happiness is largely dependent on what happens to me.					
35. People who have the marks of success (good looks, social status, wealth, or fame) are bound to be happier than those who do not.					

APPENDIX 17

The Patient Satisfaction Scale (PSS).

Name_____ Date _____

Instructions

You were in Ward 20, Liff Hospital recently. We should like you to tell us how you felt about your stay in hospital. We would like you to give us your honest opinion about the care and treatment you received. To simplify matters we have drawn up a list of questions, along with some short answers. We want you to give us your opinion by circling the X above the answer which most closely represents how you feel. Here is an example:

1. How much information were you given about your admission to the ward?

X	X	X	(X)	X
None	a little	Some	a lot	I was fully informed

We have also left a space for you to make any comment about your answer, should you wish to do so.

Please take as long as you like to complete the questionnaire. However, try not to spend too long thinking about your answer. Put down exactly how you feel about the question as you are reading it.

Thank you very much for your help.

1. How much information were you given about your admission to the ward?

X	X	X	X	X
None	a little	Some	a lot	I was fully informed

Comments

2. Were you introduced to all the nurses on the ward ?

X	X	X	X	X
None of them	one or two	a few	most of them	all of the nurses

Comments

3. How did you feel about the nurses when you first came in ?

X	X	X	X	X
difficult to approach	I felt uncertain	a little unsure of them	quite approachable	very approachable

Comments

4. Were you shown around the ward ?

X	X	X	X	X
not at all	a little	some	quite a bit	shown all of it

Comments

5. Was your treatment explained to you ?

X	X	X	X	X
not at all	a little	to some extent	quite a bit	very fully

Comments

6. How willing were the nurses to speak to you ?

X	X	X	X	X
very unwilling	a little hesitant	hesitant	quite willing	very willing

Comments

7. Did the nurses explain things to you as they went along ?

X	X	X	X	X
never	very rarely	sometimes	usually	always

Comments

8. How much time did the nurses spend talking to you ?

X	X	X	X	X
very little	a little	some	quite a lot	a lot of time

Comments

9. How did you feel when you were with the nurses ?

X	X	X	X	X
tense	a little tense	sometimes tense/ sometimes relaxed	quite relaxed	very relaxed

Comments

10. How easy was it to confide in the nurses ?

X	X	X	X	X
very difficult	a little difficult	sometimes easy/ sometimes difficult	quite easy	very easy

Comments

11. How much understanding did the nurses have of your illness ?

X	X	X	X	X
None	a little	some	quite a lot	very knowledgeable

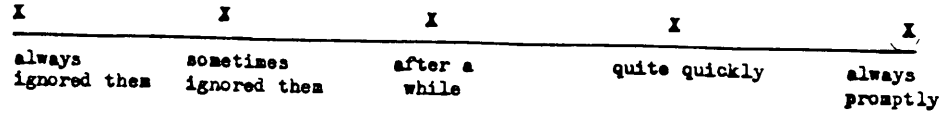
Comments

12. How did the nurses respond to your problems ?

X	X	X	X	X
paid no attention	paid some attention	paid a little attention	paid quite a lot of attention	always took an interest

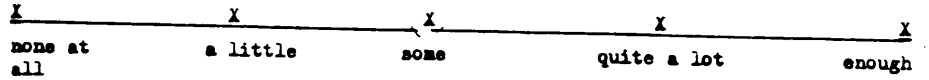
Comments

13. How did the nurses deal with your problems ?



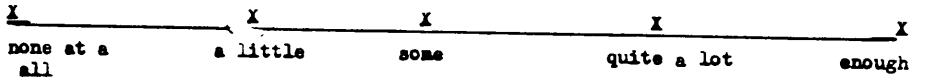
Comments

14. How much privacy did you have ?



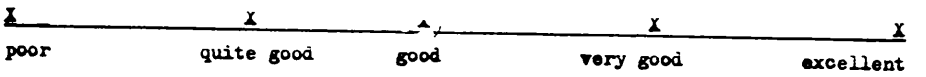
Comments

15. How much information did you get about your discharge home ?



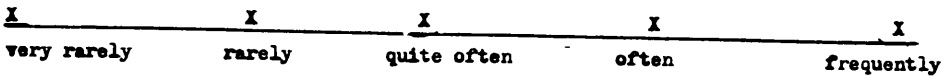
Comments

16. What did you think of the nursing care you received overall ?



Comments

17. How often did you see and talk to a doctor on the ward ?



Comments

18. How did you find the questions the doctor asked ?

X	X	X	X	X
difficult to understand	a little difficult	sometimes clear/ sometimes difficult	quite clear	very easy to understand

Comments

19. How easy did you find it to ask the doctor a question ?

X	X	X	X	X
very difficult	quite difficult	sometimes easy/ sometimes difficult	quite easy	very easy

Comments

20. What did you think of the doctor's answers to your questions ?

X	X	X	X	X
very unsatisfied	unsatisfied	sometimes happy/ sometimes unsatisfied	quite happy	very happy

Comments

21. How did you feel when talking to the doctor ?

X	X	X	X	X
tense	a little tense	sometimes tense/ sometimes relaxed	quite relaxed	very relaxed

Comments

22. How helpful were the drugs you received ?

X	X	X	X	X
not at all	a little helpful	sometimes helpful/ sometimes not	quite helpful	very helpful

Comments

23. Did you get the kind of treatment you expected ?

X	X	X	X	X
not at all	to some extent	didn't know what to expect	largely what I expected	exactly what I expected

Comments

24. Did you get the kind of treatment and help you wanted ?

X	X	X	X	X
Not at all	to some extent	I was unsure about what I wanted	largely what I wanted	just what I wanted

Comments

25. How much contact did your visitors have with the staff ?

X	X	X	X	X
not nearly enough	a little	some	quite a lot	plenty of contact

Comments

26. How much opportunity did your family have to discuss your illness with staff ?

X	X	X	X	X
none	a little	some	quite a lot	lots of opportunity

Comments

27. How much information were your family given about your treatment ?

X	X	X	X	X
none	a little	some	quite a lot	plenty of information

Comments

28. How much information did your family receive about your discharge ?

X	X	X	X	X
none	a little	some	quite a lot	plenty of information

Comments

29. How did your family feel about the staff ?

X	X	X	X	X
very unhelpful	unhelpful	sometimes helpful/ sometimes not	helpful	very helpful

Comments

30. Overall, how happy were your family with the treatment you received ?

X	X	X	X	X
very unhappy	quite unhappy	uncertain	quite happy	very happy

Comments

31. How much spare time did you have on the ward ?

X	X	X	X	X
far too little	too little	about enough	too much	far too much

Comments

32. How easy was it for you to keep yourself occupied on the ward ?

X	X	X	X	X
very difficult	difficult	sometimes easy/ sometimes difficult	easy	very easy

Comments

33. How free did you feel to do what you wanted on the ward ?

X	X	X	X	X
not at all	to some extent	sometimes	quite a lot	very free

Comments

34. Do you feel that you were treated as an individual on the ward ?

X	X	X	X	X
not at all	to some extent	sometimes	quite a lot	always

Comments

35. Did you ever feel like packing up and going home ?

X	X	X	X	X
never	hardly ever	sometimes	quite a lot	many times

Comments

APPENDIX 18

Vignettes of three subjects, one from each of the experimental Groups.

RNC Subject 5. 'Mary' was 42 years of age when admitted to the study. She has two previous admissions, one two years previously, the other 16 years earlier, when she was diagnosed as suffering from an 'affective psychosis' on both occasions. Both periods in hospital lasted approximately two months, where she was treated with antidepressant medication and supportive psychotherapy. She had been married for 12 years, but her husband was living and working in South Africa and had not contacted her for several months. She had two children aged seven and six years and described herself as a housewife, who was 'comfortably off' finacially. She attributed her admission to a delayed bereavement reaction, following the death of her father.

SE Subject 5. 'Jean' was 35 years old and had five previous admission for an affective illness, prior to her admission to the study. Her first two admissions were in 1978 and 1979, when she was diagnosed as 'manic depressive psychosis: depressed'. Admissions three and four were both in 1980, when she was diagnosed as 'mixed affective type'. Her most recent admission, was in 1984, less than one year before admission to the study, when she was diagnosed as 'manic depressive psychosis: depressed'. Her previous lengths of stay in hospital ranged from seven to 12 weeks, during which time she was treated with Lithium Carbonate and various antidepressants. Prior to her first admission, she was seen as an out-patient for a 'puerperal psychosis', following the birth of a handicapped child. She was married with two children aged 15 and 10 years. She had worked as a cleaner, but was now unemployed. She expressed no financial worries but complained that her husband was not very supportive. She lost a son in 1974 and gave birth to the handicapped son (now aged ten) one year later.

MCT Subject 2. 'Sarah' was 34 years of age and had five previous admissions to hospital, prior to entering the study. These admissions were in 1982 and 1983, with two occurring in 1984, the year before she entered the study. On the first three admissions she was diagnosed as suffering from a 'paranoid psychosis', but on the most recent admission was diagnosed as 'manic depressive psychosis'. The lengths of stay ranged from six to 19 weeks, the longest being the second admission. Drug treatment with major tranquillisers and antidepressants was used on all four admissions, with ECT given the second and third admissions. She divorced her first husband and had two children, aged 12 and 13, from this marriage. She remarried two years prior to her last admission. Her husband is in the armed forces and both children are at boarding school. She described herself as a housewife. 'Living abroad' and her 'cruel first husband' were identified as precipitating factors for previous admissions. On the most recent admissions she described anxiety concerning her sister's failing marriage and most recently an 'unreasonable fear' which she could 'not disclose to anyone'.

APPENDIX 19

The patient's manual, 'Understanding your feelings... and solving your problems.'

understanding your feelings and..... solving your problems

PHIL BARKER 1983

WHAT IS THIS BOOKLET ALL ABOUT?

This booklet was written to help people who are depressed. At first you may feel that nothing can be done to help you. Perhaps, you want to change things but feel that you do not have the energy, or do not know how to.

In the following pages we shall try to explain what is happening to you. We shall try to explain depression. We hope that this will help you understand yourself better. This may be helpful when you try to solve your problems.

In the first section, we give you **our view** of depression. What causes depression? What can be done to overcome it? By the time you read this, we will have begun to work this together - to try to solve some of your problems.

OVERCOMING YOUR DEPRESSION

Part of your treatment will involve 'cognitive therapy'. This is a kind of **psychological** help. You will receive this along with the medical help (like drugs) which the doctors prescribe for you.

Cognitive therapy is a well established treatment. However, we only offer it to some patients: those who will benefit most. The therapy will be carried out by nurses on the ward. They will also visit you at home to help keep up your progress. These notes explain what depression is, and how cognitive therapy can help you to overcome it.

What is depression?

The most obvious sign of depression are changes in your moods. You feel different to normal. You cry when there is nothing to cry about. You feel sad and alone in the world. You lose interest in yourself and in what is going on around you. You do not feel like doing anything. You blame yourself for trivial faults or shortcomings. You may even feel guilty about things which happened a long time ago. Sometimes these feelings of sadness or emptiness change dramatically into a false sense of happiness. You get very excited: full of energy and fun. This may only be a mask for the sense of sadness which you feel.

How does depression come about?

These kinds of feelings are brought about **mainly** by the way that you think - about yourself, your life and the future. You become depressed because of the way you **interpret** things which happen to you. You may take trivial things too seriously. You may underestimate how well you are coping when things go wrong. You may blame yourself for things which aren't your fault.

Although you see your **feelings** as your main problem, the real problem is the way that you **think**. The way you tend to criticise yourself. They way you try to take responsibility for everything which happens to you. How pessimistic you are about things ever changing in the future.

Because your 'thinking' is so important, it is worthwhile trying to change the way you think. If you can change the way that you think, this may change how you feel.

Is that all there is to depression?

Thinking plays a large part in making you depressed. Other things are involved too. Things can go wrong with your body. This can make you feel depressed. Some people believe that they become depressed **just** because something goes wrong inside them. This may not be true as far as you are concerned. It may be that **physical** (or bodily) problems and **psychological** (or thinking) problems have **together** produced your depression.

Some people are more likely to become depressed than others. This has something to do with how their bodies work. But this is just like saying that some people are more likely to become overweight or tense or frightenened of flying. These also have something to do with your physical make-up. But people can **learn** to overcome their problems. In much the same way, you can learn to conquer your depression. It will take a lot of hard work: from you and the nurses working with you. But it can be done.

What will be involved?

Cognitive therapy involves you working with the nurses to solve your problems. You will find out what kind of life-problems you have. Then you will learn **how** to solve them. This will ease your distress. It will help reduce your feelings of depression. The therapy that follows, usually goes this way:

First, you learn how to become **more active**. Depressed people often become inactive:- they feel that they have no energy, or things no longer give them any satisfaction. The first thing you will learn is how to **become more active**.

The next step helps you to get more **pleasure** and **satisfaction** out of life. Depression often takes this away. You are going to learn how to get it back.

Then you can start looking at the way you think about **yourself**, your **life** and the **future**. You will learn how to spot your 'thinking errors'. You will learn how changing the way you **think**, changes the way you **feel**.

Once you know what kind of thinking errors you are making, you need to practise changing the way you think, every day. You learn to question things you have been 'saying to yourself' over the years. You learn how to think more positively, about yourself and life in general.

Finally, you will learn how to use this new knowledge to deal better with your life. You will learn how to 'nip problems in the bud'. You will learn how to **avoid** making the mistakes which might bring on another bout of depression.

A word about homework

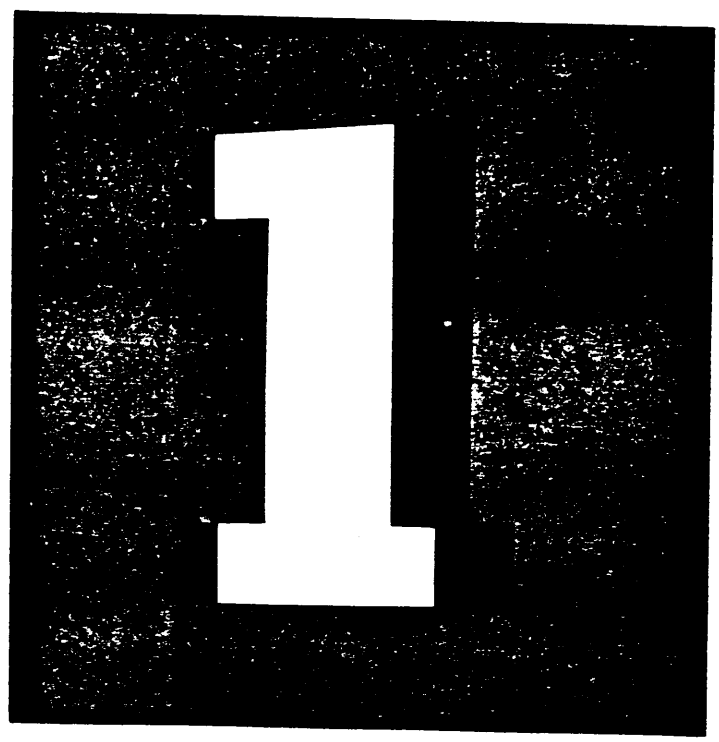
The therapy is a bit like a course at school or college. In cognitive therapy however, you learn about **yourself**. Just like school, you will have to do some **homework**. Mostly, this will be no more than keeping a note of how you feel from day to day. However, such notes are important, they show how much improvement you are making. Progress sometimes is slow. Every little sign of progress is important. Later on you will be able to jot down your thoughts and feelings. These notes will be helpful when you are trying to change the way you think.

Some people get nervous about homework. Our first rule is - DON'T WORRY. We aren't going to ask you to do any more than you can manage. If you are unhappy about ANY aspect of the therapy, simply ask the nurses, and something will be worked out.

ACTIVITY AND DEPRESSION

One of the most obvious signs of depression is that you become less active. Everything seems to be such a chore. Everything seems to be so difficult. Nothing seems to satisfy you. The simplest solution is not to bother.

In this first section, we shall look at the part activity plays in helping you to overcome your depression. We shall look at ways to get you moving again - especially when you don't feel up to it.



ACTIVITY: A REFRESHER COURSE

Depression is a vicious circle. It slows you down, mentally and physically. Everything seems such an effort. You get tired easily; you do less than you used to; then you criticise yourself for not doing enough. You begin to think you can't do anything at all, and that you'll never get over it. This makes you more depressed. It then becomes even more difficult to do anything. And so it goes on, getting worse and worse.

STEPPING OUT

Activity is one way to break this vicious circle. Trying to become more active is important for a number of reasons:

- **Activity makes you feel better.** Activity takes your mind off your painful feelings. You feel that you are **taking control** of your life again. You are doing something worthwhile. You may even find that there **are** things that satisfy you, once you try them.
- **Activity makes you feel less tired.** Normally, you rest when you are tired. when you are depressed the tiredness you feel is different. It is a sure sign that you need to become **more** active - not less. Doing nothing will only make you feel more lethargic and exhausted. Activity will freshen you up: make you **less** tired.
- **Activity makes you want to do more.** Depression often makes you feel like doing nothing at all. When you start becoming active again, the more you do, the more you feel like doing.
- **Activity helps you think better.** Once you become more active, you find it easier to solve problems. You start to think more clearly.
- **Activity makes you look better.** People who matter to you will be pleased to see you doing more.

OBSTACLES

Getting going again isn't always easy. This is usually because of 'negative thoughts' which stand in your way. These negative thoughts are typical of depression. When you decide to try something you may find yourself thinking:

"I **won't** enjoy it, so why bother?"

"I'll only make a mess of it, I **always** do."

"It's too difficult, I'd **never** manage."

These **negative** thoughts block you from becoming active. Later on, we will help you to **challenge** these thoughts, so that you can get these obstacles out of your way. Just now, simply find out what you **are** doing, and try to do more of the same.

FOLLOWING YOUR PROGRESS

Depressed people often think that they are doing **nothing**. They often think that they are achieving nothing, and enjoying nothing. This is all part and parcel of being depressed. They find it difficult to organise their time properly. Often they can't even find the time to do the things they used to enjoy doing.

We want to start keeping a record of what you do. This will show you how you are spending your time. Then you can use it to plan your day so that it becomes more active and enjoyable.

AN EXAMPLE

Here is an example. This shows what a woman on the ward was doing over a whole week. She simply made a note of what she was doing **each hour** of the day. You need not write a lot: just make a note. When you discuss your record with the nurse, this will jog your memory. It will remind you what you were doing at any hour of the day.

Example

Everyday Things

For the first few days of this exercise, just write down what you are doing just now. You can see that what we are looking for are just ordinary, everyday things. Don't feel that you have to do anything **special**. This is a practise in using the record sheet.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
8 - 9	Had Breakfast	—	B/FAST				
9 - 10	Helped with dishes	SAW DOCTOR	WENT TO O.T				
10 - 11	Talked to SARA	UPSET - SPOKE TO B.	O.T				
11 - 12	/	SLEPT	O.T				
12 - 1	LUNCH	LUNCH	LUNCH - NOT HUNGRY AT ALL				
1 - 2	TEA + SMOKE	WENT FOR WALK	BUS TO TOWN WITH JANICE				
2 - 3	PHONED J. HAD READ	WENT TO CANTEEN	COFFEE IN LITTLEWOODS				
3 - 4	READING	PHONED DEREK	'WINDOW-SHOPPING'				
4 - 5	TOOK A WALK	WALKING	BACK TO HOSPITAL				
5 - 6	TEA	TEA (NOT HUNGRY)	TEA.				
6 - 7	DID TEA DISHES	DISHES!!	WATCHED T.V. (DOZING)				
7 - 8	WATCHED TV NEWS	READ PAPER					
8 - 9	SLEPT	LAY ON BED					
9 - 10							

USING YOUR RECORD

You now know how to fill in your record. Now we want to help you to use it as an aid to overcome your problems. Your record can become a HELP rather than a HINDRANCE.

Here are some simple rules to follow:

1. **BE FLEXIBLE**

   Use your record as a **guide**, rather than a god. Things will happen to throw you off your stride. This may make filling in your record difficult. Someone may ask you to do something or go somewhere. Don't let this put you off. Just carry on filling in the record when next you can.

2. **THINK OF OTHER ACTIVITIES**

   Some things you plan to do may be affected by things outside your control: like the weather or the washing machine breaking down. Try to have another activity ready, in case your plan breaks down.

3. **STICK IN**

   If you can't do what you had planned, DON'T try to do it later on. Just carry on to your next planned activity. Plan what you have missed for the next day.
   If you finish something sooner than expected, take a break till your next activity. Have a cup of tea, smoke a cigarette or read the paper. **Have a menu of such activities to choose from.**

4. **PLAN BY THE HOUR OR HALF-HOUR**

   Try not to be too specific with your plan. Don't be too vague either. 'Tidying-up' is too vague. Listing every thing you plan to dust is too specific. Find a happy medium.

5. **QUANTITY NOT QUALITY**

   Plan to spend time (like 30 mins) on an activity. **Don't** plan how much you **want to achieve** in that time. What you achieve depends on a lot of outside things, like interruptions or things breaking down. If you say that you **must** do all your washing and for some reason you don't, you will end up feeling bad. Instead, simply plan to spend some time washing.
   Remember the golden rule: IF A THING'S WORTH DOING - IT'S WORTH DOING BADLY.

6. **STICK TO THE TASK IN HAND**

   Remember your aim is to stick to your plan. You are **not** planning to overcome **all** your problems right away. If you work steadily at becoming more active, you will eventually feel better. But don't expect to get over your bad feelings after watching T.V. for half-an hour. You'll only disappoint yourself.

7. **LOOK AT WHAT YOU'VE DONE**

   At the end of each day, look at what you have done, and what you'd like to change tomorrow. If you didn't stick to the plan, don't worry. Try and find out what the problem was, and how you might change it. Did you plan too much? Did you feel tired? Were you trying for too much success? You can learn from this.

8. **YOU ARE ALWAYS DOING SOMETHING**

   Sitting in a chair is activity. So is going to bed, or staring out the window. You are **always doing something.** But remember, these activities may not give you much in the way of satisfaction.

LOOKING FORWARD

Now you know how you are spending your day, the next step is to plan each day in advance. You are going to plan for activities which will give you a sense of satisfaction or enjoyment.

There are three good reasons why you should plan ahead.

1. By planning **in advance** you will feel that you are taking control of your life again. It will give you a sense of purpose.
2. The plan will prevent you from being swamped by minor decisions. It will keep you going even when you feel bad.
3. When you **write down** your plan, things will look less difficult. You will have broken down the day into little bits: each of which you can mange on its own. This is better than trying to fill a long, shapeless, stretch of time.

Each evening, take a few minutes to plan for tomorrow. Pick a time when you know you won't be busy, or distracted.

Simply make a note of what you plan to do tomorrow (in pencil), against each hour of the day. If you find it difficult to plan out the whole day, then just plan the morning. You can then plan the afternoon at lunch-time tomorrow.

Try to get a balance between activities which would be a challenge to you - but not too difficult; and others which would give you some pleasure - no matter how little.

Remember the golden rule - DON'T TRY TO DO SOMETHING WHICH IS BEYOND YOU. Keep your plan simple, and don't rush yourself.

BE PRACTICAL

When you are depressed you often find yourself doing the same things every day. You often put off doing the things you **need** to do, or would **like** to do. And so the pile seems to get bigger and bigger, and soon overwhelm you completely. How can you start to change this?

There are some things you can do to help yourself get started doing what **needs** to be done. These hints might help you.

1. Make a list of all the things you have been putting off.
2. Ask yourself which of these needs to be done **first**? Which is next important? Arrange the list in order of priority. If you can't decide, put them in aphabetical order. The important thing is to do **something**.
3. Take the first task. Break it down into small steps. What do you **need to do** to complete it?
4. Go through the steps in your mind. If you think of anything which might stop you doing it, write it down. Try to work out how to get around this obstacle.
5. Write down any negative thoughts you have about doing things.
6. Take each task **step-by-step**. Do it exactly as you did in your mind. Deal with any negative thoughts you have by putting them to one side. Put them in a box - you will deal with them later. Tell yourself just to stick to the task in hand.
7. Stop when you are **winning**. Avoid stopping when things start to go badly, as sometimes happens. Do just a little bit more - then stop when you are on top. You will feel so much better.
8. As soon as you finish, write down what you have done on your record sheet. Then rate the activity for Mastery and Pleasure - as we discussed earlier.
9. Focus on what you have **achieved**. Avoid thinking about what you still have to do. Keep an eye out for any negative thoughts which might make your 'success' appear any less than it really is. Write these negative thoughts down also.
10. NOW YOU ARE READY TO MOVE ON TO THE NEXT TASK ON YOUR LIST. **WELL DONE**

STICKING TO IT

Here are some hints to help you stick to your plan.

1. **Set aside some time each evening to note what you have done that day, and what you plan to do tomorrow.** Choose a time when you won't be interrupted, and when you have time to spare.

2. **If you find doing something difficult, tell your muscles what to do.** Give yourself specific instructions. Saying "go on, do it" or "get on with it" is too vague. On the other hand, saying "Legs, walk" or "Hand, pick up a pen, now write" will get you started.
   As soon as you have told yourself what to do - do it. Don't give yourself time for any doubts to creep in. Do what **needs** to be done.

3. **Watch out for negative thoughts.** If you get any negative thoughts DON'T listen to them - **write them down.** Then try to answer them, and act on your answers. (The section on THOUGHT-BLOCKS shows you how to do this.)

4. **Get rid of distractions.** Turning off the T.V. or going off somewhere quiet will help you concentrate upon what you are doing.

5. **Avoid Bed.** Bed is for sleeping in, not for **hiding** in during the day. If you think you need to relax during the day, try to plan another way of relaxing: like sitting in a comfortable armchair reading, or listening to music.

6. **Reward yourself for what you have done.** When you have completed an activity you might, for example, plan time for a cigarette or cup of tea, by way of a small reward. These rewards are most important, as they help to spur you on and lift your spirits.

7. **Arrange reminders.** You can use a kitchen timer to plan the start and finish of activities. Put up signs to remind you what you are supposed to be doing. **Tell** your family or friends what you have planned for a certain time. They can remind you if you get distracted.

8. **Give yourself encouragement.** Always start the day with something which will give you a good sense of achievement, and which you have a good chance of completing.

9. **Try to balance your day.** Aim for a balance between mastery and pleasure activities.

10. **Stick to things which you have found rewarding or fulfilling in the past.** If you enjoyed things once before, there is a good chance that, once you get going, you will enjoy them once again.

HOW DOES THAT MAKE YOU FEEL?

You have been noting what you are doing from day to day. The next step is to record how these activities make you **feel**.

From now on we want you to record how you feel about what you are doing. We want to find out how much **satisfaction** or **enjoyment** these activities give you.

Activity can give you two kinds of **positive** feelings.
You can feel a sense of:

MASTERY - when you do something which is difficult; or which you usually avoid doing.

Or you feel a sense of:

PLEASURE - when you get some sort of enjoyment from doing something.

We want you to measure how much MASTERY or PLEASURE feelings you get from the things which you are doing, each day.

The way to do this is quite simple:

1. First of all, write down what you do, hour by hour.

2. Next, try to judge how much **satisfaction** you got from doing the activity: this is your sense of MASTERY.
   Try to measure how much MASTERY you felt. Measure it on a scale between 0 and 10. A score of 0 means that you felt **no sense of achievement** at all. On the other hand, a score of 10 would mean that you felt a **great deal of achievement**.

3. Next, mark this on your record sheet. Put the letter M beside the activity: and put your score beside the letter. Here is an example below.

10.00	Went for a walk M 4	
11.00		

4. Now try to judge how much **enjoyment** you got from doing this: this is your sense of PLEASURE.
   Try to measure how much PLEASURE you felt. Again, measure it on a scale between 0 and 10. A score of 0 means you felt **no sense of enjoyment** at all. On the other hand, a score of 10 means that you felt **a great deal of enjoyment**.

5. Now mark this on your record sheet. Put the letter P beside the activity: and put your score beside the letter. Your example now looks like this:

10.00	Went for a walk M 4 P 2	
11.00		

   Now your record shows **what you have done**: how much **MASTERY** you felt; and how much **PLEASURE** you felt.

REMEMBER - always record your feelings of MASTERY and PLEASURE **as soon as you have done something**. DON'T wait until later on. By then you may have forgotten how you actually felt at the time.

ALSO - try to judge how difficult the activity is for you **now**. Try to avoid saying "I used to be able to do this with no difficulty". Give yourself credit for what you are trying to do NOW.

What's the point of all this?

You are probably thinking - "this is stupid. What's the point in doing all this? This isn't going to make me feel better. What's this got to do with me being depressed?"

We understand how you feel. It is difficult to see how some of the things we are asking you to do, are going to help. Try to take our word for it. Trust us. Would we ask you to do things which weren't going to help?

However, there are good reasons **why** you should keep these records.

1. When you are depressed, you often feel that you can do **nothing**. Or you feel that when you do something that you **don't enjoy it** or that you **haven't done it well**.

   These records give you a very accurate record of **what you have done**; and exactly **how you felt** about it.

2. Depressed people often tend to see only the black side of things. They see faults very clearly and ignore the good points.

   This is another reason why we want you to keep these records. If we asked you tomorrow what you did today, you would probably say:

   "Not much" or "Nothing worth speaking about".

   This is only natural since you are depressed: that's why you think in this **negative** fashion. By keeping these records, you can **look back** on what you **actually** did - rather than on what you **felt** you did.

These are two very good reasons for keeping these records:

- they give an honest picture of what you are doing and how you are feeling, during each day; and
- they will be helpful in challenging your **belief** that you do nothing: or that you enjoy nothing.

We understand that you may find all of this difficult to do. It may also be hard to understand. Remember these points:

- You are trying to find out more about yourself - so that you can understand yourself and the reasons why you get depressed. The easiest way to do this is by taking 'notes' on what you are doing, and how you react to what you are doing.
- Overcoming depression can be slow at the start. Try not to be too impatient. Remember, Rome wasn't built in a day.
- Remember that much of your present problems stem from your **negative** view of things. We are trying to help you towards a more positive view of your life, and of yourself. Even if it doesn't appear to be giving good results - KEEP ON TRYING.

THOUGHT-BLOCKS

When people get depressed, it is their **negative thinking** which keeps them depressed. If depression doesn't just 'pass by', then there is sure to be **negative thinking** keeping you depressed.

To overcome your depression 'catch' your negative thoughts as they happen, and then **challenge** them. These thoughts are telling you depressing things. That's how you stay depressed. The way to handle these thoughts is to **answer them back**.

Below are some of these thoughts. Beside each negative thought is a **suggestion** about how you might answer it back. This is not the **right** answer - or the **only** answer. It is just a suggestion. As you practise 'answering back' you will be able to come up with answers which suit you, and make sense to you.

NEGATIVE THOUGHT	ANSWER
"I can't do anything. There are too many problems."	There are problems in doing anything - that's life. How would I deal with this if I wasn't depressed? Is there anyone who can advise me?
"I can't stick to this plan. I've never been a record-keeper."	Keeping a plan is a skill I can learn. I haven't done this before - doesn't mean that I can't do it if I try. After all, I've used lists before - like for shopping. I could start just by making lists.
"There's too much to do - I can't cope."	I just **think** that because I'm depressed. If I write down what I've to do, it won't seem so difficult. I don't have to do it all at once. Take one thing at a time.
"It's too difficult."	It just seems that way because I'm depressed. I've done more difficult things than this before.
"I don't know how to go about it."	Have a go - don't try to produce a perfect performance. Better to try and see how I get on, than not to try at all.
"I don't want to."	I don't want to do it now - but I did earlier on. Anyway, that doesn't matter. The point is, it would be better for me to do it.

"I don't think I'm up to it just now. I'll wait till I'm feeling better."	I won't know if I'm up to it if I don't try. If I wait till I feel like it, I'll never do it. Anyway, doing it will make me feel better.
"I've wasted too much time. There's no point - it'll only make me think of all the time I've wasted. I should have done it last week."	I haven't wasted time. I have just done something else with the time. The point is - what am I doing now? Am I going to to dc more of the same or something different?
"I can't decide what to do first."	The important thing is to do **something** Do things in alphabetical order if you like. Once I get going I'll have a clearer idea of what to do next.
"I'll only make a mess of it. There's no point in trying."	I won't know till I try. Anyway, nobody's asking for a 5-star show. Even if I made a mess of it - it's not the end of the world. I can learn from my mistakes.
"I won't enjoy it."	How do you know? Since when were you a fortune teller? Try it and see.
"I'm not doing anything."	Write down what you do and see. Maybe you just **think** that you're doing nothing.
"But I'm not doing anything worthwhile."	Nobody's asking you to judge what you're doing, **just do it.**
"I don't deserve to enjoy myself."	Pleasure will make me feel better. That's good in itself. It'll also help me to do things better.
"O.K., I washed the dishes - so what?"	Normally that wouldn't have been very difficult. Now it's very difficult. In spite of that, I did it. I can give myself credit for that. My mastery score **should** be 10.

THINKING AND DEPRESSION

Now that you have begun to be more active, we can take a look at your feelings of depression in more detail. What sort of feelings are you getting? What sort of thoughts are related to these feelings?

At the beginning of the booklet, we said that your feelings of depression were brought about by the way that you think. In this section, we take a close look at the way that you think. What do you think about the things which happen to you? What effect do these thoughts have upon the way you feel?

HANDLING NEGATIVE THOUGHTS

We have discussed how depressed people tend to think in a negative sort of way. They tend to have a negative view of **themselves** ("I'm no good"), their world ("life has no meaning"). and the **future** ("things will never get any better").

These thoughts make you depressed, and prevent you overcoming your problems. We are now going to look at ways of dealing with such thoughts.

Negative thoughts have this in common:

1. They are **automatic** - they just 'pop' into your head, without any effort on your part.
2. They are **distorted** - they do not match up to the real facts.
3. They are **unhelpful** - they keep you depressed and make it difficult to change things.
4. They are **plausible** - they appear genuine: it doesn't occur to you to question them.
5. They are **involuntary** - they are very difficult to switch off.

The more depressed you are, the more negative thoughts you will have. The more depressed you are and the more you are likely to believe them, and the more depressed they will make you. This is the 'vicious circle' we have already mentioned.

Negative thinking has an effect on how you feel, and what you do. Now it is time to do something about this.

We are now going to talk about ways of 'catching' your negative thoughts: ways of recognising **when** you are thinking negatively. Once you can do this, you will learn how to look for more positive, or helpful ways of looking at the things which happen to you.

At first, you may find it difficult to 'catch' and answer your negative thoughts. Don't be discouraged. This will get easier with practise. Soon it will become more natural. Catching and answering negative thoughts is a **skill** - something you will need to learn. We will help you learn how to do this, and you will be able to practise 'catching and answering' your thoughts, as part of your 'homework'.

On the next page is a form which helps you find out what kind of thoughts you have in different **situations**. It also helps you find out how these thoughts affect the way you feel.

You will use this form in the first part of this new exercise. This will help you become aware of **how** you think.

IDENTIFYING YOUR NEGATIVE AUTOMATIC THOUGHTS

We have discussed how the way you feel is influenced by the way you **think**. I want you now to practise finding out what sort of thoughts you have when you feel bad. Think about the last time you felt bad; you might have felt sad, or angry; guilty or frightened. Try to remember how you felt and what was happening around you, and answer the following questions.

Feelings

How did you feel? Embarassed

How bad was the feeling - measure it by using a scale of 0 - 100 (100 is the very worst).

Score 60

Situation

Where were you? In Supermarket

What were you doing? Shopping - knocked jar off shelf

What was going on around you? Assistant stopped to help.

Were you thinking about anything in particular? How can I pick this up without dropping my basket?

Automatic Thoughts

What thoughts just "popped into your mind" at that time?	SCORE
She thinks I'm stupid	100
Why do I always drop things?	95
Now I look frustrated	90
I'm just hopeless	80

Did you **believe** these thoughts? Measure to what extent you believed them using a scale 0 - 100. (0 means you did **not** believe them at all; 100 means you believed them **completetly**).

HOW YOU THINK

The first step in dealing with your negative thinking, is to know **how you think**, and its effect on **how you feel**.

Negative thoughts make you feel bad. They make you feel sad, anxious, hopeless, angry or depressed. Instead of being overwhelmed by these feelings, you can learn to use them as a **signal** for taking some action. Start taking notice of **when** your mood changes. Take note of what was happening, and what was running through your mind just beforehand. Over a few days, you will become more aware of changes in your feelings. You will also become more aware of the thoughts which spark off these changes in mood. You may find that the same thoughts occur over and over again.

Becoming Aware

On the last page, is an example of a form which you can use to practise 'catching' your negative thoughts. This is how you use it.

1. Whenever you feel **bad**, make a note of 'how you felt'. Write this down in the space provided.

   Now try to measure how bad you felt. Use the scale 0 to 100. The score of 0 means that **you didn't feel bad at all**; 100 means that **you couldn't have felt any worse.**

2. Now make a note of **where you were**, when you started to feel bad. Also, write down **what you were doing**: e.g. reading, or talking to someone.

   Try to note also, **what was going on around you**: e.g. people were arguing, or the radio was blaring.

   Finally, make a note of any **general thoughts** you were having: you might have been worrying about something, or planning a shopping trip.

3. Next, make a note of any **thoughts which 'popped into your head'** just before you started to feel bad.

   Try to write these down word for word.

   Some of your thoughts may take the form of 'images'. For instance, you may imagine yourself being unable to cope with something. If that happens, just write down what you saw in your mind's eye.

   Sometimes you may not be able to identify any thoughts. If that happens, try to imagine what the situation means to you. What does it tell you about yourself, your life, or the future? This may give you a clue as to why a situation makes you **feel** sad or angry or anxious.

   Lastly, try to judge how far you **believe** these thoughts. Use the same 0 to 100 scale. 0 means that you don't beleive them **at all**. 100 means that you believe them completely,

   Remember, you can score anywhere between 0 and 100.

TAKE TIME

It may be difficult to record your thoughts **as they happen**. Don't worry about that. Simply make a mental note of the things which have distressed you during the day. Then set aside a few minutes later on, to write these down. If you can't remember exactly what happened, and what you thought at the time, try doing an 'action replay'. Try and remember **what happened**, how you **felt**, and what you **thought** at the time.

TAKE CARE

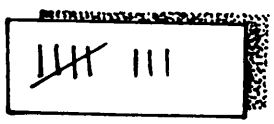
Beware of 'excuses' for **not** watching your thoughts. You may say "I'll do it later" or "I'd better just forget about that". You may be tempted to simply avoid looking your thoughts in the face. It is quite natural to want to avoid thinking about unpleasant things. But remember in your case, **challenging** your negative thinking is the best way of fighting your depression.

If you find yourself making excuses, it is probably because you have been thinking something really important . . . . . so **write it down**. don't hide from it. Once you have done that, you can then practise some distraction to ease your feelings of distress. But remember, just ignoring your thoughts won't make them go away.

COUNTING THOUGHTS

Another way of making you more aware of your thoughts, is to **count them**. Counting can also make them less distressing. When you count thoughts, this gives you a chance to stand back from yourself. It is almost like counting cars which pass you in the street; you stand to one side in order to count - rather than stand in the middle of the road getting run over by every car that passes.

You can count negative thoughts any way that you like. You could tot them up on a knitting counter, or simply tick them off on a card in your pocket or handbag as shown here:



At the end of the day, you can add up how many negative thoughts than ever. This is probably just because you are getting better at 'catching' them. In the long run, they will become less frequent.

Remember NOT to blame yourself for having so many negative thoughts. This is simply a sign of your depression: it is **not** a sign of any weakness or inadequacy on your part.

TACKLING YOUR THOUGHTS AND FEELINGS

You have spent some time looking at the way you think, and how this affects your feelings. Now we want to look at how you can deal with these thoughts. In this section, you will begin to challenge some of your commoner thoughts: thoughts about yourself or your life in general. You will deal with your feelings by practising more logical ways of thinking.

In the next few pages, we offer some general hints about 'logical thinking'. We end with a simple word of warning. It is likely that you have been thinking 'negative thoughts' for some time: perhaps for most of your life. Do not expect to change this pattern easily: the change you desire may take a little time.

CHALLENGING YOUR NEGATIVE THOUGHTS

Now you are more aware of your negative thoughts. The next step is to take a closer look at these thoughts. Are they really "true"? Are they really "helpful"? Is there a more helpful or realistic way of looking at your life?

QUESTION YOUR THINKING

There are four ways of altering your negative thoughts. Ask youself:

1. **What is the evidence?** Why do you think the way you do? What **facts** back up what you think? Do these facts support what you think, or contradict it?

2. **What other views are there?** There is more than one way of looking at a situation. How else could you look at what has happened? Try and list other viewpoints. What evidence is there - for and against these views? When you try to look at these objectively, which view appears to be the most correct?

3. **How do these thoughts affect you?** The way you think, affects the way you feel. How do these thoughts affect how you feel and what you do? How helpful is it to think this way? What are the disadvantages of thinking this way? Can you think of thoughts which might have a better effect upon you?

4. **Are you mistaken?** Depressed people often distort things. They may jump to conclusions: blame themselves for things which are not their fault; exaggerate the importance of things, and so on. Are you making such errors in the way you think about this situation?

Shortly, we shall talk more about questioning as a way of challenging your negative thinking. Before we do this, let us look at the record sheet which can help you do this.

CHALLENGING: THE RECORD SHEET

It is important to write down and challenge as many automatic thoughts as you can, each day. By writing them down, you become more objective. In the end, you may be able to answer, or challenge such thoughts in your head. At first, it helps to write them down. Your answers will be stronger if you can read them in black and white. You may need to spend some time working out "challenges" (or answers) to your thoughts on paper, before you can deal with such thoughts in your head. However, the more you practise, the easier it will get.

Over the page is an example of the record sheet we want you to use. This has two extra columns on it. You will use these to **challenge** your thoughts.

In the first columns you write down the day and date; how you **felt** what was **happening** to you; and what you were **thinking**, just as you have done already.

Challenge In the next column write down as many challenges to those thoughts as you can imagine. Then ask how much you believe these "other views". If you don't believe the answer at all, give it a score of 0%. If you believe it completely, give it a score of 100%. You could score anywhere in between.

Outcome In the last column we want you to do three things:

1. Look at your original thoughts. Now that you have tried to challenge it, do you still believe it to the same extent? How far do you believe it now? Give it another score out of 100.

   You should find that your belief in the automatic thoughts has weakened. If it hasn't, perhaps you are ruling out your 'answer' in some way. Maybe you are saying that this may apply to other people, but not you: or that you are just fooling yourself. If you are doing this, write down these 'negative thoughts' and try to answer them in the same way.

   Don't expect your belief in the negative thoughts to disappear right away. You probably have been thinking such thoughts for some time. The "answers" which you have come up with are new. It may take some time for you to believe in them completely.

DAILY RECORD OF NEGATIVE AUTOMATIC THOUGHTS

DATE	EMOTIONS(S) What do you feel? How bad was it (0-100%)?	SIUTATION What were you doing or thinking about?	AUTOMATIC THOUGHTS What exactly were your thoughts? How far did you believe each of them (0-100%)?	RATIONAL RESPONSE What are your rational answers to the automatic thoughts? How far do you believe each of them (0-100%)?	OUTCOME 1. How far do you now believe the thoughts? (0-100%)? 2. How do you feel? (0-100%) 3. What can you do now?

Outcome (cont'd)

2. Now take a look at your FEELINGS column. Check how you felt before you challenged your negative thoughts. How do your feelings compare now? Do you still feel **exactly** the same? Give **each** of the feelings you listed another rating of 100 for severity.

   You should find that your painful feelings have lessened a little. Don't be discouraged if they have not gone away. This will take time and practise. Have patience.

3. Lastly, ask what you can **do** to make things better. How might you test out some of the 'thinking answers' you offered as challenges? Think about **how you would like to handle that situation** next time it happens. What will you do **if** you find yourself thinking and feeling this way again? Try to work out a plan to use in the future, if this happens again. You could also think of a plan to stop the same thing happening again. Remember to write down exactly what **needs to be done**.

-oOo-

AN EXAMPLE

Over the page is an example. This has been filled in by a depressed woman. She has recorded how she felt one day after she had received a letter from her sister. She felt very angry and jealous. These feelings did not occur for no reason. She felt that way because of how she thought about the letter. She had three very clear 'negative thoughts'. These **thoughts** made her feel bad - not the letter itself.

In the last two columns, she tried to think more clearly about the letter. She tried to deal with the real 'facts'. She tried to challenge the thoughts. By thinking more rationally she was able to reduce the pain of the angry and jealous feelings. Finally she tried to work out what she should do to stop these bad feelings returning.

Here is an example of a form which might help you challenge some of the thoughts you commonly use.

On this illustration, we can see that this peron had some bad feelings on **Monday the 15th of September**. She had a letter from her sister. She felt angry and jealous. These feelings were about 80% of the most she could ever feel. She had **three different thoughts** about this letter. Firstly, **"why does my sister have all the luck?"**; second, that her "whole life has been a disaster": and third, that she will "never get out of the rut".

At the time, she believed these thoughts about 95%: very strongly indeed.

DAILY RECORD OF NEGATIVE AUTOMATIC THOUGHTS

DATE	EMOTIONS(S) What do you feel? How bad was it (0-100%)?	SITUTATION What were you doing or thinking about?	AUTOMATIC THOUGHTS What exactly were your thoughts? How far did you believe each of them (0-100%)?	RATIONAL RESPONSE What are your rational answers to the automatic thoughts? How far do you believe each of them (0-100%)?	OUTCOME 1. How far do you now believe the thoughts? (0-100%)? 2. How do you feel? (0-10%) 3. What can you do now?
Monday 15 Sept	Jealous Angry (80)	Got a letter from my sister saying she had just got a new house	How come she has all the luck? My whole life has been a disaster! I'll never get out of the rut (95)	She is lucky to have a new house - but everyone can't be so fortunate. Some people are starving. Am I starving? of course not. I just think my whole life is a mess if I'm honest I haven't done so badly. (75)	1. My thoughts - (50) 2. My feelings - (40) 3. I could make a list of my recent successes. I could start putting away some money in my own bank account. I could make a list of things I would like to change.

When she challenged these thoughts, things weren't quite as she thought:

- she reasoned with herself: although her sister was "lucky to have a new home, **everybody** can't be so fortunate".
- she recognised that she just **thought** that her whole life was a mess.
- finally, she realised that 'never' is a very long time. Perhaps she should try to to change her life gradually.

She did not believe these thoughts completely (only about 75%). This kind of rational thinking reduced her belief in her automatic thoughts. After reasoning things out, her feelings of jealousy and anger weren't quite so bad. Finally, she planned to start changing things which she was unhappy about - in a gradual way. Doing what needs to be done!

LOOKING FOR ANSWERS

Ten questions over the page will help you find "other viewpoints" or other ways of thinking about situations. You will find these on the back of your "daily thinking record". Here we offer some ideas about how these questions can help you think more clearly.

A. WHAT IS THE EVIDENCE?

The first thing you need to tackle is the **evidence** for thinking the way you do. Just because you **believe** something to be true, does not mean that it **is** true. Would others accept your thought as true? If your thought was put 'on trial', would it stand up in court? Or would it be dismissed as irrelevant, or circumstantial?

1. The key question here is, "are you confusing a **thought** with a **fact**?" What is the **evidence** for thinking the way you do? It is not enought to say "well that's what I think!" What evidence do you have to support this thought?

AUTOMATIC THOUGHT	POSSIBLE ANSWER
(When I passed Sally in the street today, she ignored me). I must have done something to upset her.	Just because she ignored me doesn't mean that I have upset her. Perhaps she didn't see me. Or maybe she had something on her mind.

In the example above, the "depressing (or upsetting) thought" is that someone has hurt you on purpose. The "reason" given is that she must be **paying you back** in some way. There is at least one other way of looking at this. Sally may not have seen you, or she might have been thinking about something else.

2. This example shows the need to tell the difference between "what you **think**" and "what is **fact**". The second question on our list can help you to look at the situation differently. Just ask yourself, "what is the evidence **against** these thoughts?" In our 'possible answer' above, we have done just that.

In challenging your negative thoughts, it may be helpful to remember the idea of the "courtroom battle". Ask yourself, "what is the evidence **for** thinking this way?", then ask yourself, "what is the evidence **against** thinking this way?"

LOOKING FOR ANSWERS

Finding 'other viewpoints' or trying to think 'rational' thoughts can be difficult. Here are ten questions which might help you challenge your negative thoughts.

A. WHAT IS THE EVIDENCE?

1. Am I confusing a **thought** with a **fact**? What is the evidence to **support** these thoughts?
2. Am I ignoring other ways of looking at the situation? What is the evidence **against** these thouhgts?

B. HOW ELSE MIGHT I LOOK AT THIS?

3. Is my view the **only** view? How would someone else view this situation?
4. Is this just DEPRESSED thinking? How would I have looked at things before I became depressed?
5. What evidence do I have to back up these other ways of thinking?

C. WHAT IS THE EFFECT OF THINKING THE WAY I DO?

6. Does thinking this way help or hinder me from getting what I want?
7. What are the pros and cons of thinking this way?
8. Am I asking questions which have no real answers?

D. WHAT CAN I DO TO CHANGE THINGS?

9. Am I overlooking simple solutions? Am I assuming they won't work?
10. How can I test my "other viewpoints"? What can I do to change my situation?

USE THESE TEN QUESTIONS AS AN AID TO "CHALLENGING" YOUR NEGATIVE THOUGHTS.

B. HOW ELSE MIGHT I LOOK AT THIS?

Our next three questions involve the way you are **looking** at the situation.

3. Ask yourself if this is the only way of looking at the situation? Often it is difficult to 'step outside yourself'. Often it is difficult to be objective. One way to do this might be to ask how someone else (a friend or neighbour) might react to the same situation. How would they look at what has happened? What would they say? If this is still difficult, try switching places with your friend. Imagine that what happened to you, has happened to a friend. She comes to you for advice, or consolation. What would you say about **your** problem to her? **Would you look at the situation differently if it wasn't happening to you?**

AUTOMATIC THOUGHT	POSSIBLE ANSWER
(I went to the shops and couldn't remember what I wanted). This just shows how my mind's going.	O.K., so I forgot what I wanted. It's hardly the end of the world. My friend Edith is always forgetting things. She just laughs and makes a joke of it.

If your friend said "I can't remember things - I think my mind's going", what would you say to her? Would you **agree** with her? Or would you come up with another way of looking at this problem? Sometimes it is easy to give **good** advice to our friends. Giving good advice to ourselves is often more difficult.

4. In much the same way our view of things can be another example of DEPRESSED thinking. You may **only** be thinking these negative thoughts because you are depressed. One way to overcome these thoughts is to remember how you would have dealt with the situation **before** you became depressed.

AUTOMATIC THOUGHT	POSSIBLE ANSWERS
(I tried reading the newspaper today, but couldn't concentrate). This shows how I am getting worse.	If I wasn't depressed, I'd probably just have got up and done something else. I would probably have said "I'll come back to this later, when I **feel** like reading."

5. The last question in this section echoes what we have already said. Ask yourself what is the evidence **for** thinking in these different ways? Is it TRUE that forgetting things **isn't** the end of the world? Is it TRUE that your friend would probably shrug off such a problem. Is it TRUE that you would probably have just gone and done something else? If your answer to any of these questions is YES, maybe you should swap these thoughts for your negative ones.

C. WHAT IS THE EFFECT OF THINKING THE WAY I DO?

Here are three more questions. These ask how useful are your negative thoughts.

6. The first question is "does thinking this way help or hinder me from getting what I want?" Like most people, you simply want to be HAPPY. Ask yourself if thinking this way helps you to become happy? Does it stop you from becoming happy? Does this kind of thought make you miserable?

AUTOMATIC THOUGHT	POSSIBLE ANSWER
My life has been a complete disaster. I've ruined my own life and now I am ruining everyone else's.	Brooding about what has happened just makes me depressed. What is done is done. The important thing is to ask yourself, what am I going to do NOW?

Often you feel that you **deserve** to be miserable. Maybe you even feel that you deserve to be **punished** more for things you have done in the past. It is important to challenge these thoughts. These thoughts keep you feeling depressed. Indeed, they may make you feel even more depressed. They also hold you back from getting what you want.

7. In the same vein, consider the pros and cons of thinking in this way. Sometimes negative thoughts **appear** to be helpful. They may keep you on your toes. But they also have disadvantages. These outweigh any advantages.

AUTOMATIC THOUGHT	POSSIBLE ANSWER
"I must always try and make a good impression on people." ADVANTAGE = "I'll go out of my way to be friendly. If they like me in return I'll feel good." DISADVANTAGE = "If someone appears not to like me, I'll feel terrible and will think badly of myself."	Telling myself that I must always make a good impression isn't realistic. This just puts more pressure on me. I become more tense and find it even more difficult to relax and enjoy myself. Instead, I should try thinking, "If people like me that's nice. If they don't, it's not the end of the world. It's not realistic to think everyone should like me."

8. Lastly, it may be that you are asking questions which have no real answer. Depressed people often ask themselves "Why aren't things different?", "What is life all about?", "Why is life so unfair?", "Why is this happening to me?", or "What can I do to undo the past?" Brooding over these questions is sure to depress you further. Like it or not, these questions have no real answers. Try turning these thoughts into a question you can answer. If you can't do this, don't wast any more time on them.

AUTOMATIC THOUGHT	POSSIBLE ANSWER
"When will I get over this depression?"	Sorry. There is no answer to that. Going over and over this just upsets me further. I'd be better asking myself what I can do to make myself feel a little better right now?

D. WHAT CAN I DO TO CHANGE THINGS?

All of these questions try to change the way you think. They also ask you to do something different as well. Like telling yourself to stop brooding; or to go and do something else for a while.

9. The last two questions ask HOW you can change things. You need to ask, "is there a fairly simple solution to my problem? Perhaps one which I have overlooked?" Often, trying to think how a friend might handle the situation can help you find such a solution. Or, you may know of a 'solution' but have argued that "it won't do any good. It won't work." **How will you know unless you try?**

AUTOMATIC THOUGHT	POSSIBLE ANSWER
"I feel awful. I have no energy. I can't stop going over and over things in my mind."	I know I feel bad. That's what it's like to be depressed. Why not take a short walk in the grounds. See if a bit of fresh air will refresh me.
"There's no point. Nothing will make me any better. Anyway, I haven't got the energy."	Look, I know that I **feel** bad. And I know that I **feel** that nothing is going to change this. But I won't know if this (taking a little walk) is any good until I try it. Stop telling yourself things won't work. Try it and see.

10. In the same way, ask HOW you can **try out** some of these 'possible answers'. Start planning HOW you can try "shrugging things off with a laugh" (instead of worrying if your mind's going). HOW can you deal with your lack of concentration? HOW you can tackle the question of "what I am going to do with my life now?"

It is not enought to THINK differently. You need to turn this into ACTION. Do something different. If you do something different, perhaps you will FEEL different. **You won't know until you try.**

In the next stage, we take another look at the way you think, and the effect this has upon your feelings. For the time being, we want you to use these ten questions as an aid to challenging your negative thoughts. Use these questions, and you will soon begin to bring your negative thoughts under your control.

A WORD OF CAUTION

Before we leave this section, we should warn you against expecting too much. There are five problems you might run into when you begin to challenge your negative thoughts.

1. Firstly, 'challenging our thoughts' is unusual. Normally we don't stand back, question and 'challenge' our thoughts. What we are asking you to do is difficult. At first you may find it near impossible to be objective. You may find that your 'answers' do not appear to affect your feelings very much. DO NOT DESPAIR. This is quite normal. Give yourself the chance to practise this challenging approach. Give yourself time to get the hang of it. Don't be discouraged if you can't master it straight away. After all, you wouldn't expect to be able to drive after only a few lessons. PRACTISE, PRACTISE and some more PRACTISE.

2. You may also find if difficult to be rational when you are feeling upset. The feelings may be so bad that you may think that you cannot think at all. If this happens, write down what is distressing you as a **distraction**. When you are feeling calmer, come back to what you have written down. Now you will be in a better position to look for more rational answers.
   Beware of making matters worse by telling yourself that this means that you are a failure: or that this approach doesn't work.

3. Remind yourself that your record does not need to be a masterpiece. It is meant to help you to face your thoughts and feelings. Even if it is just some notes and jottings this might be enough for you. Try to remember that there are no right answers. A "good answer" is one which will help **change** the way you feel; or weaken your faith in your negative thoughts. Try to find the answer which works for **you**.

4. Beware of criticising yourself when you are writing down your thoughts. You might find yourself thinking "I must be stupid to think that" or "this just shows how bad I really am". REMEMBER, these are merely further negative thoughts which are part and parcel of your depression. Your negative thinking is the problem: not your intelligence or your goodness.

5. Lastly, don't get depressed if you find that the same thoughts keep cropping up over and over again. Your negative thinking is probably a well established habit. Your thinking has become a bad habit which will take some time to break, like giving up smoking or trying to stop biting your nails. Try to take the view that the more often a particular thought occurs, the more chances you have to challenge it, and break the habit.

CLEAR, COOL, THINKING

Over the next few pages are some of the common thinking errors which trouble depressed people. It is worth saying that they trouble **most** people. But they trouble depressed people more seriously. These thinking errors are examples of **illogical** thinking. In each of them you will say something to yourself which either is not true; is an exaggeration of the truth; or cannot be proven by any evidence. These thinking errors put you down in some way. They make you feel bad. They are very unhelpful. Our aim in trying to teach you to recognise them is to follow the old saying: "to be forewarned is to be forearmed." If you can catch these thinking errors early on, you may be able to challenge them more quickly. As a result, you may be able to avoid feeling distressed, or you may be able to reduce the extent of your bad feelings.

Don't be surprised if you find that you don't use all of these thinking errors. You may use some more often than others. Some you may not be aware of at all. However, we expect that you use some of them quite often. These are the real culprits as far as your depression is concerned.

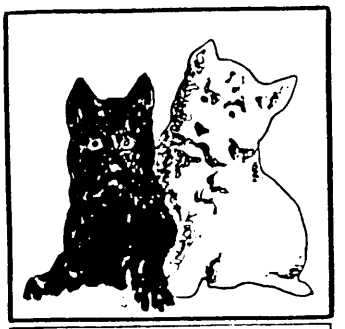
We have tried to illustrate these thinking errors with little pictures and symbols. You will get a copy of these to keep in your pocket or handbag: to help you recognise the thinking error, and to help you to challenge it.

At this stage, you are learning how to recognise thinking errors so that you can catch them all the more easily. Now you are becoming more knowledgeable about what **causes** your feelings of depression. You are becoming more able at catching the negative thoughts which produce your feelings of depression.

THINKING ERRORS

You have now been introduced to the idea of thinking errors and the part they play in negative thinking. In this section, we discuss these thinking errors in more detail. Here you will develop your awareness of the kinds of thinking errors **you** make, as you make them.

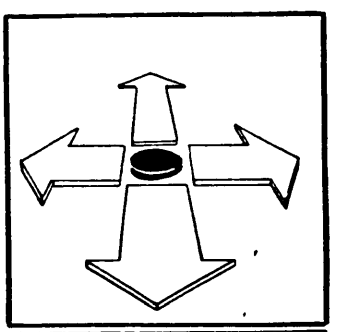
If you can learn to 'catch' your thinking errors, you may be able to prevent patterns of negative thinking becoming established.



BLACK+ WHITE THINKING

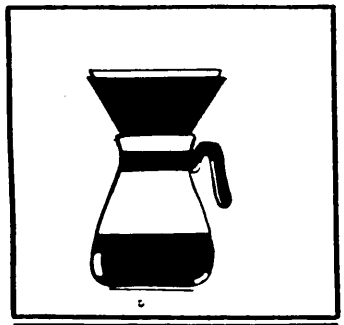
Do you tend to see things in 'black-and-white'? For instance, are you either a **total** success, or a **total** failure? If **one** thing goes wrong does this mean that **everything** is wrong? This error can be called 'all-or-nothing thinking.' You seem to be saying to yourself "if I am not perfect, I must be a complete mess", or "if everyone doesn't love me, then nobody loves me." You are making it a case of **all- or-nothing**. Try and check this error by asking yourself, "what is the evidence for saying that **everything** is wrong, or that **nothing** is right." It may be true that **some** things are wrong, or that **some** improvement could be made in a situation. This is not the same as saying that everything is wrong, or nothing is right. Try to remember that reality is made up of a thousand shades of grey. You are not all good or all bad; all right or all wrong. **There is no black-and-white.**

Do you tend to use one bad experience to colour other parts of your life? Do you ever make a mistake, or fail at something and say to yourself, "I never get **anything** right." This is an example of **over-generalisation**. Just because you fail at **one** thing doesn't mean that you fill fail at **everything**. Maybe you fall out with a friend and end up saying "nobody loves me." You are taking your feelings from one situation, and colouring other situations in an equally bad way.



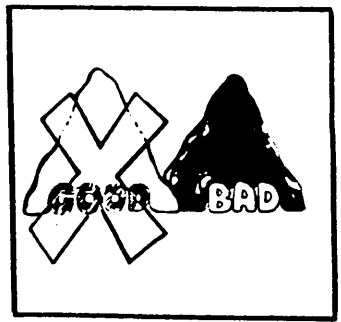
OVER-GENERALISING

The best way to tackle this is to ask for the evidence. How do you know that nobody loves you; or that you never get anything right? There is no need to pretend that there is **no** problem. But there is no value in transferring your unhappiness form one situation to the rest of your life. Try to tell the difference between things which are really 'bad' or unpleasant, from those which you have 'coloured' black by over-generalising.



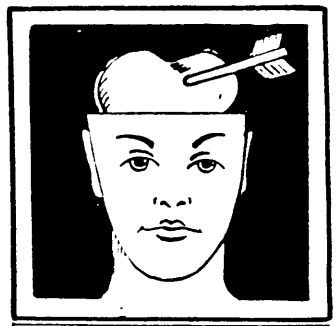
MENTAL FILTER

Most things which happen to you will not be all bad. They will be made up of 'bad bits' and 'good bits'. Do you tend to think only of the bad bits? This is a bit like making coffee with ground coffee. However, instead of keeping the water which passes through the ground beans, you keep the grounds instead. Even when making coffee there is a 'good bit' (the coffee liquid), and a 'bad bit' (the coffee grounds). When you find yourself saying "I didn't have a minute's happiness today" or "my life has been just one problem after another", you may well be using the **mental filter**. You may be concentrating only upon the bad bits - throwing away any 'good bits'. Start tackling this error by checking the evidence. Make a list of all the 'bad bits'; and then try to list the 'good bits' - no matter how small they appear by comparison. Beware of 'filtering' out the bad experiences, and dwelling upon them.



DISCOUNTING THE POSITIVE

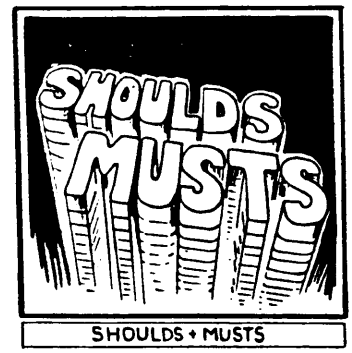
In a similar way, you might be telling yourself that some 'good bits' **don't count** for some reason, You might say, "OK, so I did my housework today. So what? I do it every day. It's hardly a success". You may be telling yourself that certain things don't count as positive experiences. You reject these as positive experiences; and end up dwelling upon the negative experiences (the bad bits). This error is another version of the mental filter. If you are obliged to recognise something which isn't really **bad**, you discount it by saying that it's not really good either. It's nothing. Try to remind yourself that filtering out good experiences only worsens your depression. **Discounting the positive** is another way of focussing on bad experiences; and another way of deepening your depresion.



EMOTIONAL REASONING

Human beings tend to be emotional. Our hearts rule our heads, much of the time. However, we need to watch that such 'emotional reasoning' doesn't lead us into trouble. Do you ever think, "I feel guilty. This must mean I've done something wrong". Or, "I know that I can't prove it but I just **feel** that it's true". These are both exanples of **emotional reasoning**, letting your heart rule your head.

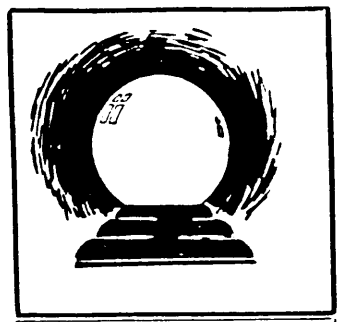
Again, search for the evidence to support feeling this way. If you can't find any, you will have to try to accept that you are being 'emotional'. You are putting yourself down for no good reason. You have a choice. You can continue to 'feel' guilty, or let down (or whatever) for no good reason, or you can say there is no reason WHY you should feel this way: then try to work out how you should be feeling.



SHOULDS + MUSTS

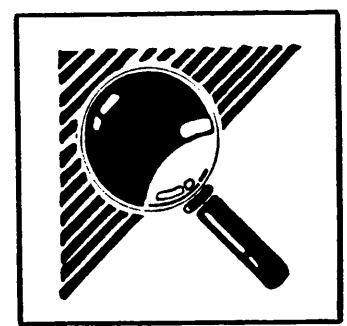
Do you ever say "I **should** be able to pull myself together" or "I **must** always try to appear cheerful" or "I **should** always want to be with my family". These kind of thoughts make heavy demands upon your emotions. They make you feel you are a failure (if you can't pull yourself together); or they make you feel that you have let others down (if you aren't always cheerful); or they make you feel guilty (if you don't want to be with your family).

It is one thing to try to be positive, cheerful or loving. It is quite another to say that you **should** or **must always** be like that. When you find yourself using "should and must" simply tell yourself to **stop trying to be perfect**. Go ahead and try to be positive, or loving or cheerful. But don't punish yourself if you can't always keep it up.



JUMPING TO CONCLUSIONS

Often, you may tell yourself that things are "bad" although you have no evidence to support this. This is a bit like crystal-ball gazing. You are predicting that certain things will happen - a bit like a fortune teller. You may tell yourself that "I'll never get over this" or "I'll never be able to do that". How do you know? Can you foretell the future? At other times, you may say that "everyone is fed up with me" or "people don't like me any more". How do you know? Can you read their minds?
Jumping to conclusions is a very common error - we all tend to dc this from time to time. The easiest way to challenge this error is to look for the evidence. How do you know that this or that will happen? How do you know that people don't like you or don't want you. There is no point just saying "well I feel that way". This is just a sign that you are **jumping to conclusions**.



CATASTROPHISING

Most of us tend to exaggerate. Maybe you do this as well. If something goes wrong, do you ever say, "Oh, this is terrible, and there's nothing I can do about it". You may well be **magnifying** the problem - almost as though you were holding a magnifying glass over it. You make it look much worse than it really is. At the same time you **underestimate** your ability to deal with it - almost as if you were looking at your own abilities down the wrong end of the telescope. You make them appear much **smaller** than they really are . You minimise yourself - you make yourself appear less able, or competent.
When things go wrong, try to avoid turning a small problem into a disaster or a complete 'catastrophe'. Search for the evidence. How bad is it **really**? Is it really so terrible? Is it really the worst thing which could happen to you? Are you really not able to do anything? Make a list of the sort of things you might at least try.

LABELLING

When things go wrong, you may find yourself sticking labels on yourself. When you have a quarrel with someone, this may **mean** that you are a "rotten person". When you try to tackle something but give up, this **means** that you are "hopeless" or "useless". You find it difficult to recognise that you are made up of "good bits" and "bad bits" - like other people. The label you apply usually suggests that you are **completely** bad, hopeless, or useless. To check this error, ask for the evidence. How do you know that you are **completely** bad? How do you know that you will **not** succeed next time round? How do you know that other people wouldn't have found this equally difficult? Beware of **labels** - they usually hide the truth.


PERSONALISATION

The last error involves thinking that "everything always happen to me". You may think that bad things - like a sudden downpour on a sunny day - is what affects you. This is just another example of your bad luck; or, you may think that in some way it is your fault. If people have an argument, it may be as a result of something **you** said. Or, if someone is unhappy, it is because **you** must have upset them. Although it is difficult to accept, the truth is that you are not really that important. Nobody is that important. Unless you can **prove** to yourself that it is your fault - by pointing to some evidence - then you will have to accept that you are making the error of **personalisation**. You are tricking yourself into thinking that things always happen to you, or are your fault. This simply is not true.

PUTTING YOUR THOUGHTS TO THE TEST

You have now learned to 'catch' your negative thoughts. You have had some practise in arguing them into submission. You have learned a bit about replacing negative thoughts with more reasonable 'answers'.

You have begun to use these 'possible answers' to change the way you act. In this section, we go a stage further. Now you will learn how to become your own 'problem solver'. You will learn how to put your negative thoughts to the test. Now is the time to start experimenting with your life. Through these experiments you can find the real value of your 'possible answers'.

ACTION - ACTION - ACTION

In the last two sections, we talked about arguing **against** your negative thoughts. Changing the way you think can do wonders for the way you feel. Just arguing with yourself, is however, not enough. You can tell yourself that these negative thoughts are unhelpful, **but do you really believe it?** We have suggested that you should test out some of your "possible answers". We advised you to take some of your own advice, by changing the way that you act. Here we talk about this at more length. We discuss how you can **challenge** your negative thoughts further: by finding out how wrong they are.

We have talked about "collecting evidence" which contradicts your negative thoughts. Now it's time to **act** on your "possible answers". Action helps you to break your old thinking habits. It also helps to strengthen new (more positive) ways of thinking.

TESTING! TESTING!

You may not think it, but you are a bit of a scientist. You make predictions about things. Then you act on these predictions. For instance, you might predict that "if I press this bell, someone will come to the door". If you were on a bus, you might expect it to stop. You might predict that if you stand in the pouring rain, you will not only get wet, but will also catch cold. When it comes to dealing with people, you might predict that "if I argue with my husband, he will stop loving me". The important thing about such predictions is that you act on them **automatically**. You very rarely ask if your predictions are true or not. **You do not test out your predictions.**

A depressed person is a bit like a scientist gone wrong. Instead of finding out if her predictions are true or not, she distorts her view of the world to fit her prediciton.

Most of the negative thoughts we have talked about, involve predictions. You might tell yourself that "I won't be able to cope", or "people **won't** like me", or "if I do that, people **will** reject me". In the last two sections, we have been trying to help you to think like a scientist. We have been **helping** you **question** your automatic thoughts. Instead of accepting these thoughts, now you are looking for alternatives. You are a bit like a scientist running an experiment in which he is testing out a theory.

TAKING ACTION

Six steps are needed to **test** your predictions.

1. Think of your prediction (or negative thought).
2. What is the evidence **for** and **against** thinking this way?
3. Think of how you can test out your prediction. This will be a little EXPERIMENT.
4. Try out your experiment.
5. Make a note of what happens **as a result.**
   - If your prediction is shown to be false , so much the better. You will belive your "possible answers" even more strongly now.

   - If your prediction is shown to be true, DON'T WORRY. This is still useful. You now have a chance to see where you were going wrong. You can work out how to think **differently**. Once you have worked out how to change the way you act, you can test this out: in another EXPERIMENT.
6. Lastly, you can draw some conclusions. You will have learned something from your experiment.

Here are a couple of examples to show you what we mean.

HARRIET

Harriet finds it difficult to talk to the other women on the ward. She thinks that she doesn't have anything to say. She regrets her lack of education. For this reason, she usually avoids mixing with the other women.

1. **PREDICTION** (The negative thoughts)	"If I talk to people, they will find out how stupid I am. They will laugh at me and I will get upset".
2. **THE EVIDENCE**	"I only **think** that they are smarter than me. Anyway, there are lots of things that I am interested in which I could talk about. Other people say 'stupid things' and laugh **along** with everyone else. How do I know that people aren't laughing just because they are happy? Anyway, what's so bad about having a poor education? There are more important things about a person than whether or not she can **talk clever**, "like being honest, or loyal or friendly".

3. **THE TEST**

"How do I know I **will** get upset if I don't try. I will sit in on the group. I'll just listen at first and talk when anyone speaks to me. I'll try and relax and show an interest in what's being said. Remember to smile at people. Look interested and other people might like it".

4. **THE RESULT**

"It was easier than I thought. By listening to everyone else, I was less self-conscious. I said something and everyone laughed. At first I blushed and was about to worry, but I checked myself. "See" I said "you've cheered somebody up".

5. **WHAT I LEARNED**

"My prediction was quite wrong. I won't say it was easy, but it wasn't half as bad as my negative thoughts said it would be".

MARY

Mary is depressed. She can't seem to do anything to shift it. She tries reading, but can't concentrate. She tries to watch television, but her mind wanders on to "negative thoughts" again. She despairs of ever getting better.

1. **PREDICTION**

"I am never going to get any better. My mind is going. I can't do anything at all. I'm going to get worse. I know I am".

2. **THE EVIDENCE**

"I know I **feel** that I'm never going to get better. But that's just my depression talking. My mind isn't really going. This difficulty in concentrating is all part of depression. Maybe I'm trying too much. And there are some things that I can do. I only think about the things I find difficult".

3. **THE TEST**

"I will try reading just a little bit - maybe just a page. Just to see if I can do it. Then I'll try watching a short T.V. programme - like the news".

4. **THE RESULT**	"Well, I read the page. But what's a page? Wait a minute, that's another negative thought. Putting myself down again. Yes, I said I would try a page and I did that. GOOD. Watching T.V. was more of a problem. The room was a bit noisy. Found it difficult to concentrate. But I kept my attention on the T.V. at least. GOOD. Someone said, "aren't you waiting for Crossroads?" and I just said "No, I've got something to do".
5. **WHAT I LEARNED**	"I found out that my predictions were quite wrong. I **can** do things as long as they are realistic. Rome wasn't built in a day. I need to take things in smaller steps. And I need to give myself more encouragement".

This is a very important stage for you. Although "challenging" your negative thoughts is important, putting them to the test is **the** BIG STEP. At the start of this booklet, we suggested that your problems stem from how you think about things which happen to you. Here, we have talked about putting your negative thoughts to the test. Are these thoughts really TRUE? Or are you **talking yourself into believing they are bad** - without any evidence.

Sometimes things will happen which WILL be unpleasant. You can use these experiences to learn that life is not always pleasant. Often it can be very unpleasant. We have tried to help you to tell the difference between things which ARE unpleasant; and things which you THINK are unpleasant. Often there is not much you can do about **really** unpleasant things. But there is a lot you can do to change your negative thoughts. Those which make you **feel** unpleasant. Putting your thoughts and predictions to the TEST is an important part of this change.

SETBACKS

You are at the stage where you are dealing directly with the thoughts which made you feel depressed. You have learned a lot about the kind of thinking errors you can make, and how to challenge them. Will it now all be plain sailing? Probably not. The road to recovery is likely to be strewn with all sorts of obstacles. Some will stop you in your tracks. These obstacles might knock you back a bit. They might be distressing. DON'T DESPAIR. Such setbacks are only to be expected. They are all part of your stages of recovery.

In the next few pages, we try to advise you about handling these setbacks. Here you can learn how to deal with setbacks when they have happened. You can also learn how to try to ensure they don't get any worse.

BOUNCING BACK

Getting over depression means making changes in your life. When making such changes things rarely go smoothly all the time. At times, things go well. You feel that you are almost over your problems. Then you hit some "black spots". You feel that your depression is overtaking you again. Things start to go wrong. Maybe everything seems to be going wrong. You wonder if things will ever get better. You may even wonder if there is any point in going on. Perhaps something has upset you. Or you may just wake up one day, feeling like this.

One thing needs to be said about this. IT IS ABSOLUTELY NORMAL TO HAVE THESE SORT OF SETBACKS. This is just another stage on the road to recovery. They are not a sign that you will never overcome your depression. Although unpleasant, setbacks have a good side. Setbacks let you learn more about yourself. They give you a chance to practise the skills which you have learned about dealing with depression. We might even suggest that you should go as far as TRYING TO MAKE YOURSELF DEPRESSED. By doing this **consciously**, you learn that YOU can push yourself down into a deep depression. Once you have done that, you can pull yourself out again, **by your own efforts**. Getting over setbacks is the stage where you learn to build up your confidence. Confidence in YOUR ability to control **your** depression.

Here are some basic rules about dealing with these setbacks. First, we offer advice about dealing with a setback when it catches you unawares. Then, we offer you some advice about developing your own plan for dealing with problems in the future.

SOME BASIC RULES

- **DON'T PANIC**

  Getting caught by a setback can be upsetting. Remember that setbacks are a normal part of getting over depression. Even people who are not depressed have their "ups-and-downs". When you are depressed, however, the downs seem to go deeper. They seem more difficult to climb out of. This is only how it SEEMS. Tell yourself very firmly - **"don't panic"**.

- **USE YOUR SETBACKS**

  Setbacks can be useful. They tell you about the sort of things which made you depressed in the first place. They give you a chance to practise the skills you have learned. Given time, you will become better at dealing with setbacks, quickly and effectively. Tell yourself very firmly - "here's a chance to learn more about myself and what makes me depressed".

- **USE WHAT YOU HAVE LEARNED**

  People often take a setback to mean that they are "back to square one". They often take this as meaning that they have failed. Ask yourself, "have I been able to work things out in the past? What evidence have I to show this? Does this not mean that I can use these skills again, this time round?" Try out what you know. Stick with these new skills. What have you got to lose?

- **GO BACK TO BASICS**

  By the time you read this, you may have made some progress. You may be at the stage of answering negative thoughts as they crop up. You have worked through several 'stages' of the therapy. That doesn't mean that you can't go back to using some of the more basic methods, to control your feelings. Maybe you find it difficult to answer certain negative thoughts. This may make you feel 'down'. Get yourself moving again by RETURNING TO BASICS. Use distraction: steer your thoughts away from your painful feelings. Start using your activity record again. Plan your daily activities. Use the M and P ratings to help you 're-discover' some of your pleasurable activities.

  Try writing down your thoughts once again. Or perhaps something is proving difficult for you to do. Again, why not **write down** what it is you have to do: break it down into stages, the way you used to do. Even people who have never been depressed find this a useful way of dealing with difficult problems. Don't be embarassed that you have to go back to basics. It's the easiest way to get going again. It makes sense.

- **WATCH YOUR BLACK AND WHITE**

As you make progress, the worse your 'down' spells will seem by comparison. In a strange way, your 'setback' is a sign of your progress. You are upset by the fact that you have "slid back" or are "running into difficulties". You only think this because you have **something better** to compare your depression with. Remember that 'ups-and- downs' are part of normal living. Don't let your 'black-and-white thinking' add to your depression.

- **ADD UP YOUR GAINS**

When you fall into depression again, it often seems as though everything is lost. THIS IS NOT TRUE. Nothing can take away the gains which you have made. Even if they seem to have gone now, they will come back as your depression lifts again. You can help to speed this up by remembering all the things you learned to do; or picked up again recently. Write them all down. Make a list of all the challenges you faced, no matter how small. Don't stint yourself. Add up each and every gain you have made recently.

- **DON'T BLAME YOURSELF**

One of the easiest mistakes to make when you are feeling depressed, is to blame yourself for what has happened. The truth is that NO ONE is to blame. We said earlier that setbacks are a **normal** part of recovery from depression. Instead of heaping blame on to yourself for your setback, look upon it as a problem to be solved. Another challenge. Don't use your setback as a stick to beat yourself with.

- **HOLD ON FOR ALL YOU'RE WORTH**

If you don't seem to be able to solve the problem of your setback, don't despair. Don't give up. Time, and a little sustained effort on your part will see you through. Remember the times in the past when you thought that all was lost. Things looked black then, didn't they? But you got over it. This time will be no different. You can bring yourself through. Just remember, when the going gets really tough, HANG ON.

PLANNING

A good way of learning to handle setbacks is to develop your own plan for what to do when one happens.

To help you do this, we advise you to sketch out **two** plans:

PLAN A tells you how you can make yourself as **miserable** as possible. This can be used to keep you miserable for a long time. The idea behind this plan is to help you become aware of how you act or think in ways which make you depressed. The sooner you know what you are doing, the sooner you can do something about changing it.

PLAN B is just the opposite. This plan shows you how you can take steps to overcome your depression. This plan helps you to work out ways of challenging your negative thoughts, and changing the way you feel.

On the next page, you will find an example of these plans. You will see that each is made up of thoughts and actions. Things you should say to yourself; and things to do. These are not the **only** thoughts and actions which you could use. They are just examples of what you might try. You might want to work out some plans of your own, based on your own experiences. Ask yourself what sort of things have you thought about or done **in the past**, which have made you feel more depressed? What sort of thoughts or actions have you used which have made you feel less distressed, or even a little better.

EXAMPLE

PLAN A	**PLAN B**
Stay in bed.	Get up and get busy. You know from experience that it will be an effort to start with, but it will get easier as you go along, and you will feel better for it. Staying in bed won't help at all.
Spend as much time as possible brooding and feeling miserable.	Involve yourself in something. Use distraction techniques. Do something active that needs a bit of concentration. Come back to answering thoughts later, when you feel better.
Leave the day shapeless and vague, and tell yourself it's all too much for you.	Plan, in detail, exactly what you are going to do. Take one step at a time. Record what you do, and give yourself marks for M and P.
Don't do anything you enjoy. Tell yourself you don't deserve it.	Make a point of doing things you enjoy, and of noticing small pleasures. It will help you to get out of the depression, and you will end up doing the things you you have to do, more effeciently.
Don't give yourself credit for anything you do.	Give yourself a pat on the back for anything you achieve. Remind yourself that when you are feeling really bad, even the simplest routine activity is an achievement. If you can, try and do one extra thing beyond the normal routine. It will make all the difference to the way you feel.
Tell yourself that you're weak and pathetic for being this way.	Remind yourself that self-criticism will do nothing to help you overcome your depression - in fact, it will make you feel worse. Give what is happening its proper name - it is a setback, nothing to do with you being weak or pathetic. Remind yourself that it is quite normal to have setbacks on the way to getting better. Try to see this one as a problem you can tackle, not a reflection of your inadequacy as a person.
Tell yourself you should be over your depression by now.	Remind yourself that there is no should about it. Think of all the things you have been doing to overcome this very tough problem, and allow yourself credit for what you have achieved.
Think about all the things you have done wrong in your life. Blame yourself for them and tell yourself what a horrible person you are.	Tell yourself that you are only human, so of course you have made mistakes in your life - it would be a miracle if you hadn't. Remember that you wouldn't expect that kind of perfection of anyone else. Ask yourself if in fact a lot of the things you have done wrong were done in good faith - they seemed the best possible alternative at the time. Remember that you've done millions of things in your life, good, bad and indifferent and that it is not fair to judge yourself only on the basis of the bad ones. Think about some of the good things you have done instead.
Tell yourself this treatment is not going to work for you, so you might as well give up. You'll always be this way.	Remind yourself what you have already achieved with it. If it has worked before, it will work again, even though it may be difficult to get started. A setback does not mean all is lost - it's a passing phase, and you can learn from it. Remember the times when this has happened in the past.

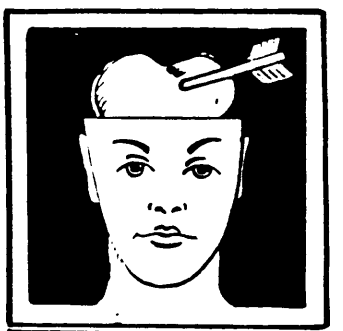
APPENDIX 20

Section from the Beck and Greenberg pamphlet,
'Coping with Depression'.

Typically, the depressed person also sees himself in a very negative way. He may believe that he is helpless and alone in the world and often blames himself for trivial faults or shortcomings. He is pessimistic about himself, about the world, and about his future. He loses interest in what is going on around him and doesn't get satisfaction out of activities he used to enjoy. Often he has trouble making decisions or getting himself to carry out decisions he has made.

APPENDIX 21

Section from the patient's manual,
'Understanding your feelings...and solving your problems'.



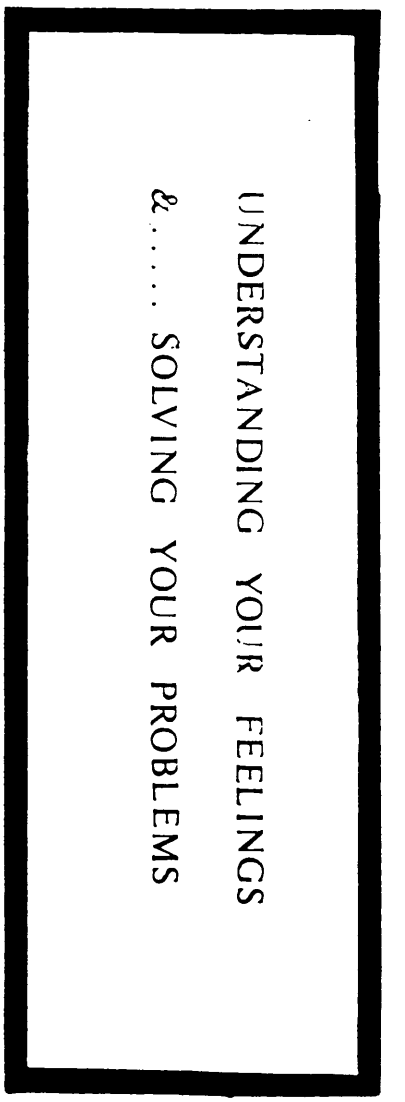
EMOTIONAL REASONING

Human beings tend to be emotional. Our hearts rule our heads, much of the time. However, we need to watch that such 'emotional reasoning' doesn't lead us into trouble. Do you ever think, "I feel guilty. This must mean I've done something wrong". Or, "I know that I can't prove it but I just <u>feel</u> that it's true". These are both exanples of <u>emotional reasoning</u>.letting your heart rule your head.

Again, search for the evidence to support feeling this way. If you can't find any, you will have to try to accept that you are being 'emotional'. You are putting yourself down for no good reason. You have a choice. You can continue to 'feel' guilty, or let down (or whatever) for no good reason, or you can say there is no reason WHY you should feel this way: then try to work out how you should be feeling.

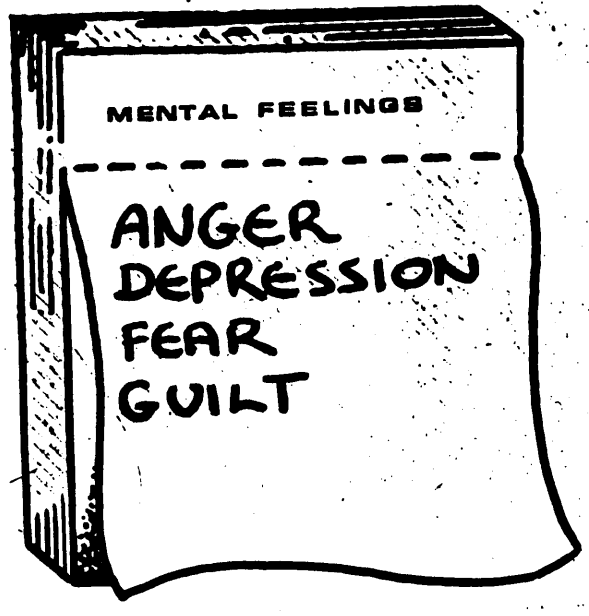
APPENDIX 22

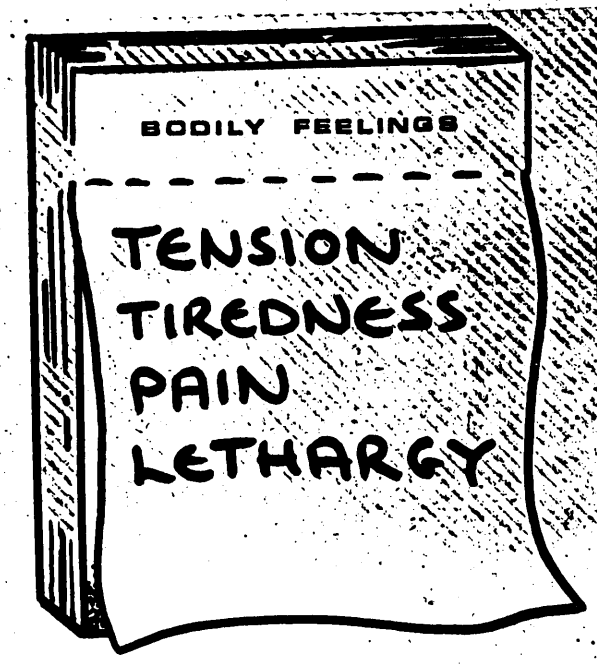
The 'flip-chart': visual aid used to illustrate the cognitive model of depression.

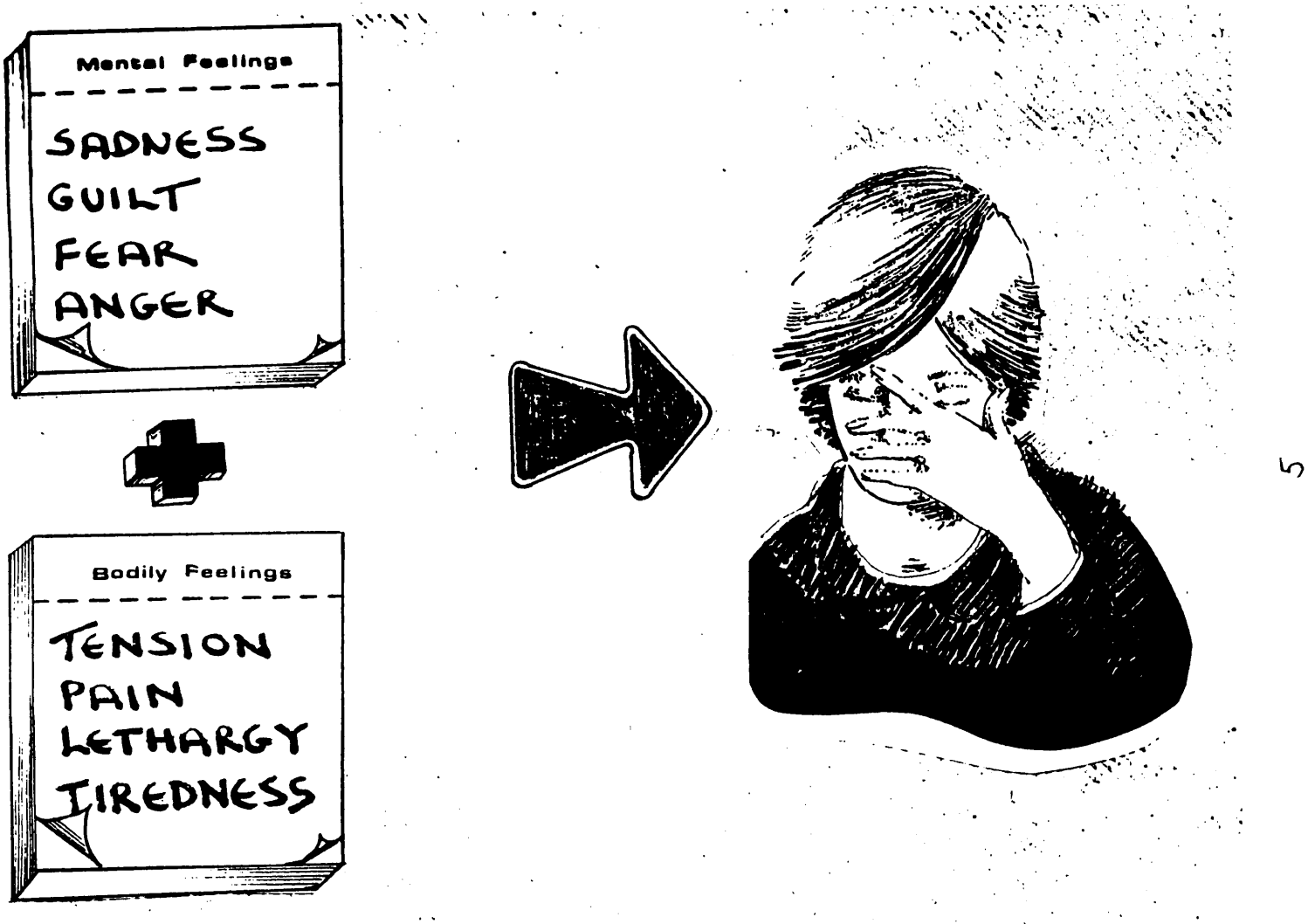


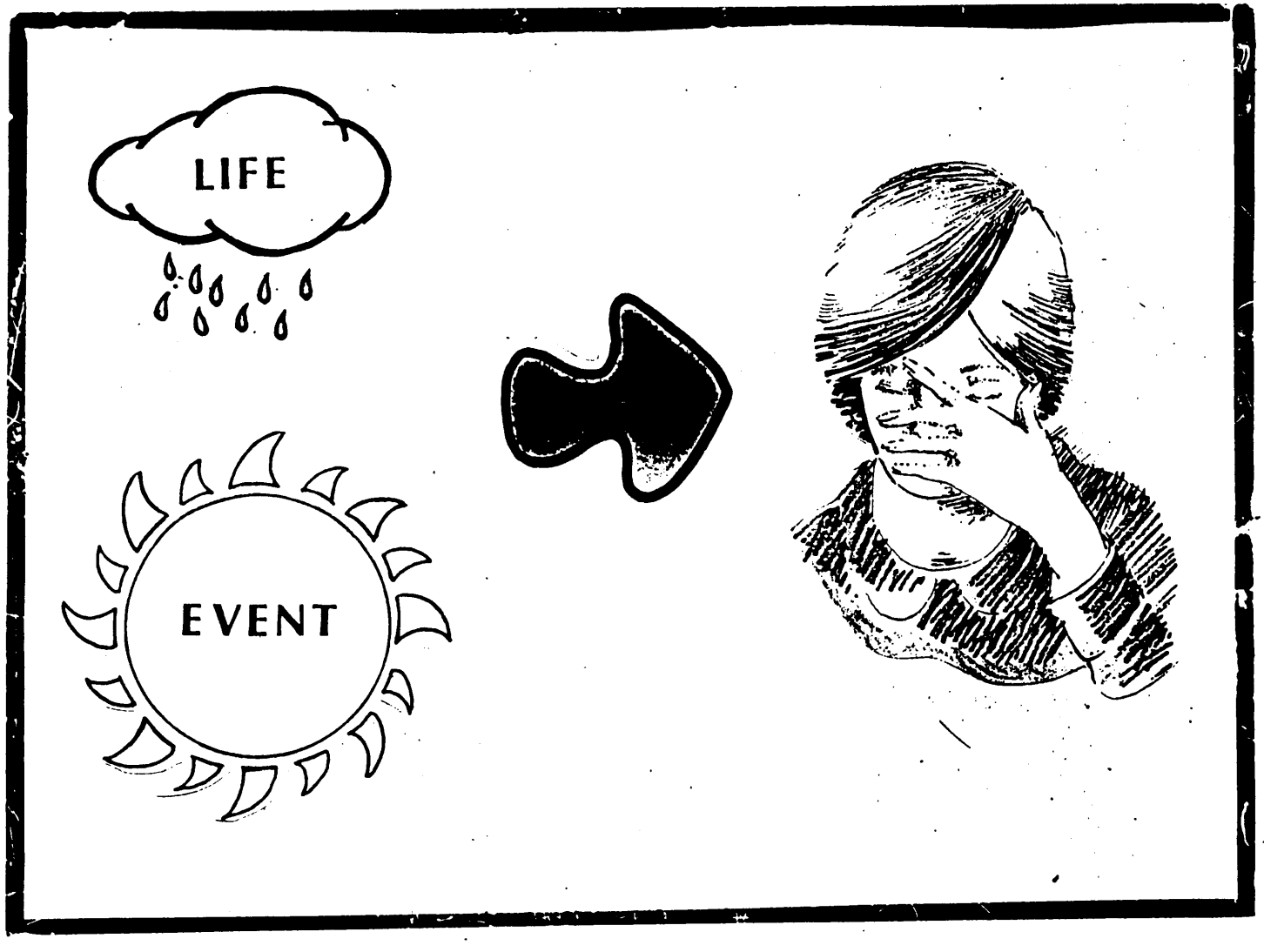

I FEEL
SO
SAD
I OFTEN
FEEL
GUILTY
I FEEL
ANGRY

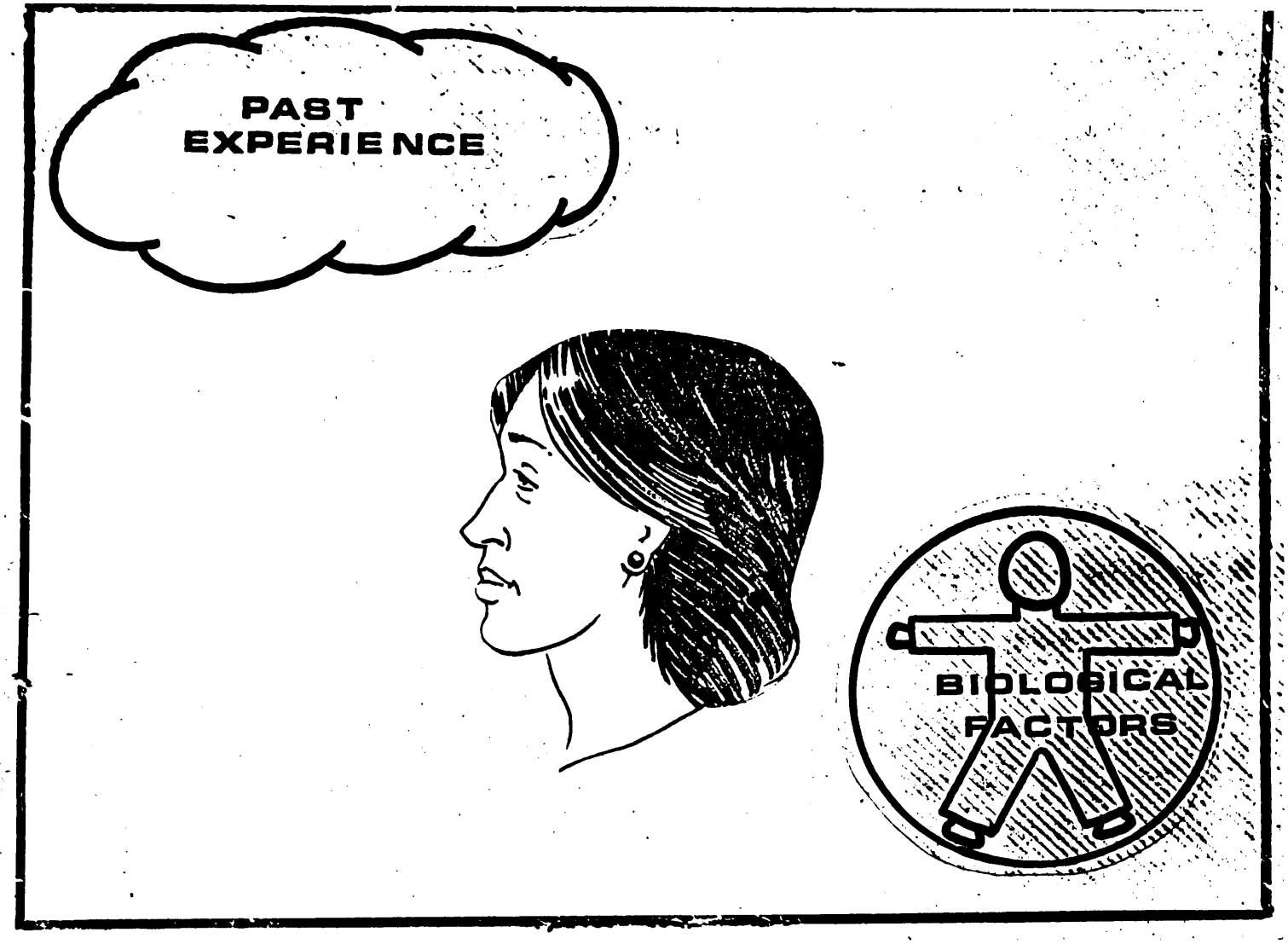
I FEEL SO BAD
I'M SO TIRED
I'M SO TENSE

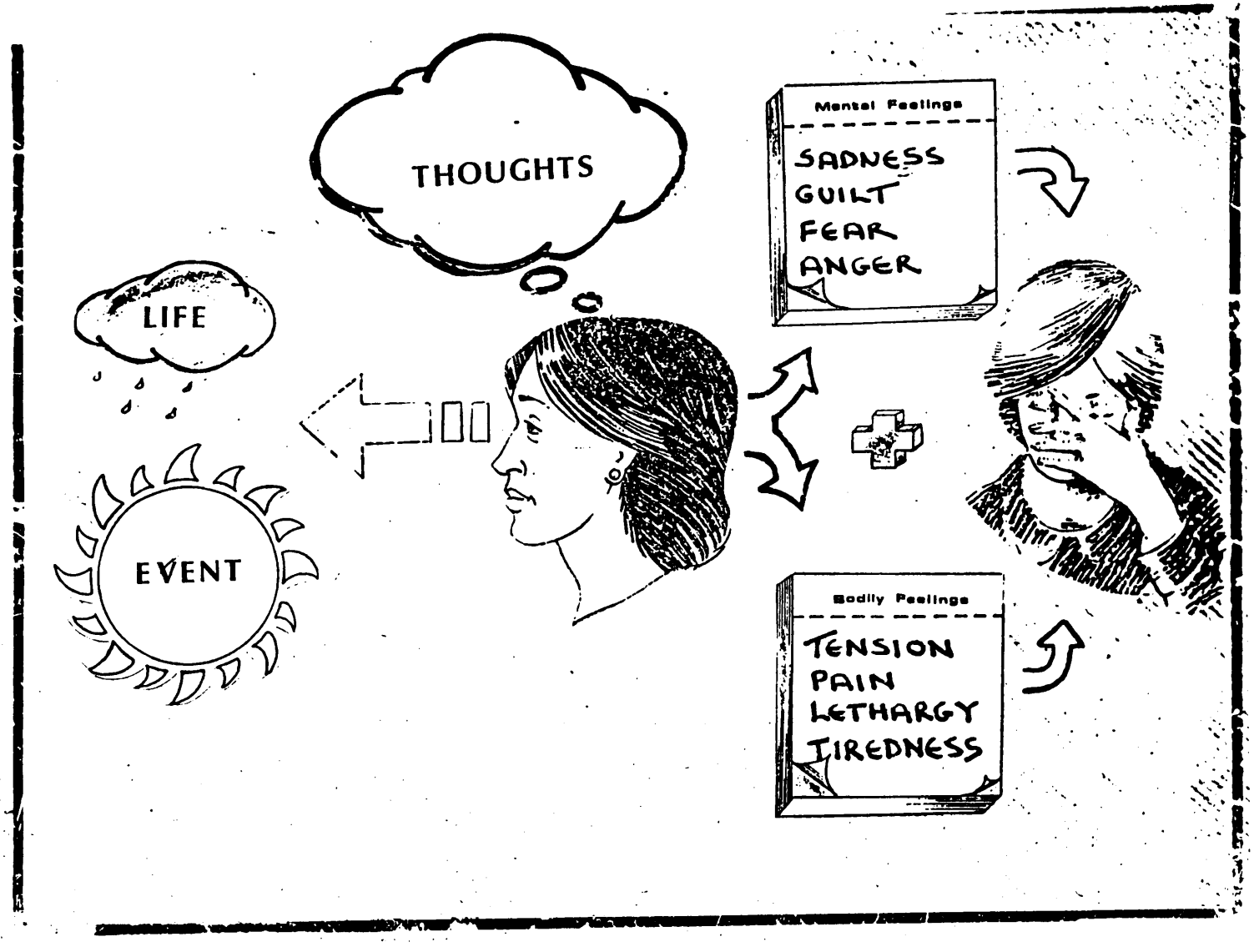

MENTAL FEELINGS
ANGER
DEPRESSION
FEAR
GUILT


BODILY FEELINGS
TENSION
TIREDNESS
PAIN
LETHARGY


Mental Feelings
SADNESS
GUILT
FEAR
ANGER
Bodily Feelings
TENSION
PAIN
LETHARGY
TIREDNESS


LIFE
EVENT


PAST
EXPERIENCE
BIOLOGICAL
FACTORS

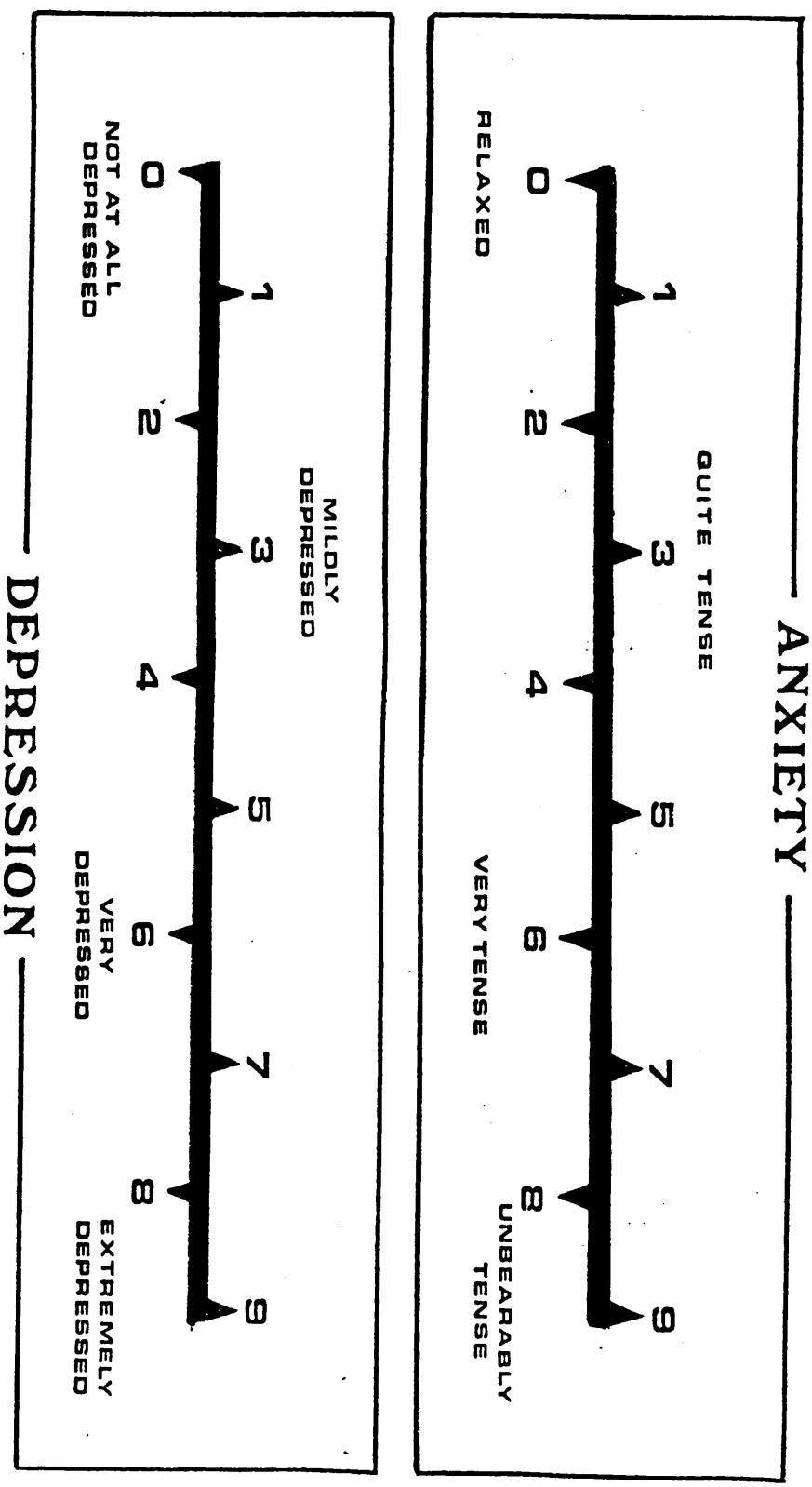

THOUGHTS
Mental Feelings
SADNESS
GUILT
FEAR
ANGER
LIFE
EVENT
Bodily Feelings
TENSION
PAIN
LETHARGY
TIREDNESS

COGNITIVE THERAPY

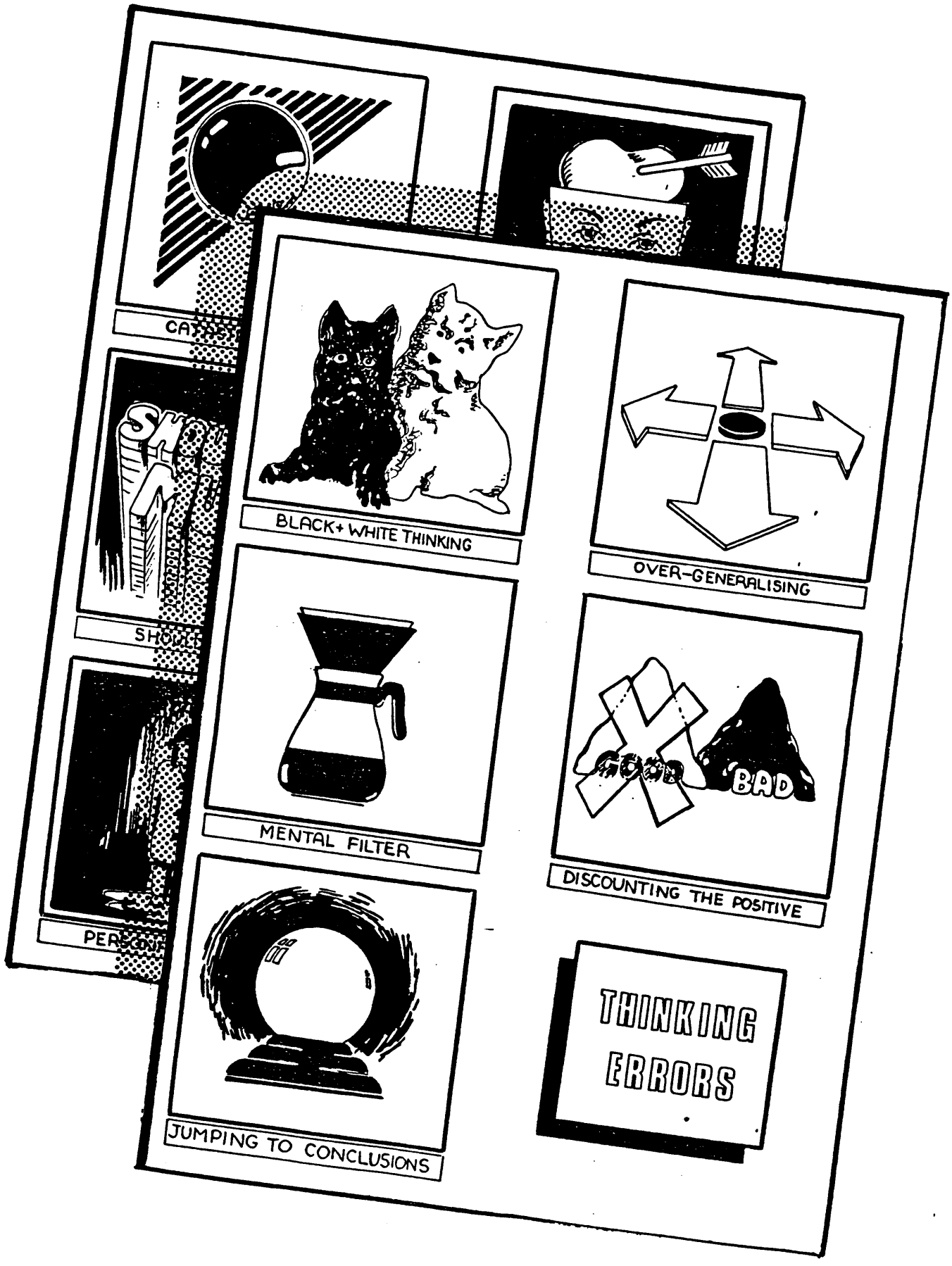
APPENDIX 23

Visual aids used to supplement use of the patient's manual

1. Visual analogue scale of anxiety and depression.



2. Thinking errors cards (to scale).



APPENDIX 24

Introductory notes provided for nurses involved with the MCT intervention.

FINDING YOUR WAY

What cognitive therapy tries to achieve couldn't be more simple. It tries to help the patient identify the errors of thinking which help produce her feelings of depression. Then it tries to help you think in a more realistic, rational way about herself, her life and what is going to happen to her in the future. this is, in principle, very simple.

Nurses are faced with two problems, in trying to do cognitive therapy. First of all, they tend to think that because cognitive therapy is very specific and has very clear guidelines about how to approach certain problems, this means that it is difficult to carry out. This is something of an illusion. In most 'psychological therapies', only the roughest of outlines is provided. Anyone wanting to 'use' the therapy has to 'ad lib' - or make it up as they go along. In cognitive therapy, there is no need to ad lib: you simpley have to follow the guidelines - adapting these slightly to suit your own personality, the way you talk and so on.

The second problem is to do with the problem of depresion itself. Even nurses with a lot of experience can be a little intimidated by the problems of depressed patients. This is largely to do with the hopelessness which they feel when faced with severely regressed - and especially suicidal - patients. The feelings of anxiety and apprehension which nurses feel when faced with such patients are only natural. It has something to do with feeling responsible for helping the patient recover or in some way find a reason for living. Let's not pretend that such a responsibility is not a tall order. However, it is clear that nurses, all over the world, in 'routine admission' units, in specialist units, in the community, are faced with the same burden of responsibility. Although practising cognitive therapy with such patients may appear to add to the burden of responsibility, the opposite is the case. This theory package should be an asset to the nurse, since it helps her find some kind of a way through the confused and often disturbing world of the depressed patient.

The motto for many a psychiatric patient trying to overcome a problem of longstanding is often the repeated phrase:

"I never said it was going to be easy. But you can do it."

Perhaps this is the sort of motto which we should adopt. All of us are trying to become psychiatric nurses: or should I say become better or more effective psychiatric nurses. Often that involves 'grasping the nettle', facing up to challenges and problems which we might rather not face. However, let's not forget, that stated very simply, all we are asking our patients to do is to 'grasp the nettle': accept that they have a problem; accept our help in finding out exactly what it is; and try to find a way to solve some of the life-problems which contribute to their difficulties. Can we ask our patients to do something which we, ourselves, are unwilling to do.

In providing you with this 'manual' for modified cognitive therapy, I want you to know that I understand your anxieties, I am aware of your apprehension. I say that with conviction because I believe that these 'feelings' are part and parcel of the lot of the 'therapist'. They are the emotional cost, which must be paid in order to gain the rewards which successful therapy can bring.

I hope that these short notes will be of some guidance to you.

GOOD LUCK and THE BEST OF THERAPY

Phil Barker

APPENDIX 25

Example of instruction to nursing staff on the use of sections from the 'patient's manual' within session.

IDENTIFYING YOUR NEGATIVE AUTOMATIC THOUGHTS

Use the form I Y N A T as the basis for this session. This will help the patient identify **what happened** around the time that she started to **feel bad**. Once she has done this, you can help her to recall her 'negative automatic thoughts' by asking her to 'replay' the scene.

EXAMPLE

"Alright Janice, you felt bad yesterday morning . . . can you tell me exaclty, how you felt?

Uh huh, you felt unhappy . . . sort of sad. O.K. How bad was that feeling? If you could rate it on a scale, say 0 to 100, how bad would it have been? 100 would be **the very worst you have ever felt** in terms of sadness or unhappiness.

O.K. about 90. Right then . . . . can you remember where you were when you **started** to feel bad?

I see . . . and what were you doing? . . . .

Yes, and what was goind on around you? was anything happening? was the radio on? people talking or anything?

O.K. And were you thinking about anything in particular? I mean were you worrying about something, or planning something in your mind . . . like that? O.K. fine."

After you have helped her fill in the form, review it as follows:

"O.K. Janice, you were sitting in the canteen, having a cup of coffee with Marjory. There were a lot of other people milling about. Some of them were arguing about something or other. You were trying to talk to Marjory about going into town on a shopping trip but you kept thinking about the noise in the canteen, and you couldn't decide whether or not to get up and leave or complain to the manageress. Is that about it? Alright then, can you picture yourself there in that situation, just as you described it to me? Alright then, tell me what sort of thoughts are just 'popping' into your head right now?

Write down clear details of the feelings, situations and automatic thoughts, along with ratings of the severity of the feelings and the patient's belief in her 'negative thinking'. This will be used for future reference, and to help the patient get used to rating her beliefs.

Once she has completed this exercise two or three times, show her how to use the 'triple-column' format: where she notes her EMOTIONS the SITUATION and her NEGATIVE AUTOMATIC THOUGHTS as they occur to her in everyday life.

At this stage, it is also helpful to gain some indication of how many negative thoughts the patient has, each day, by asking her to **count thoughts** using a simple tick system, or - if available - using a tally counter.

Over the page, are copies of the notes which you should ask the patient to read as back-up to the instruction given by yourself.